The Experiences of Therapist and Bereaved Clients of using an Acceptance and Commitment Therapy approach to grief.

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Abstract

Background and Aims: Whilst bereavement is a generally a normal process of adjustment, for some individuals the outcome can be more serious. Current bereavement research has produced inconclusive results to date and been criticised on many levels. A gap has been identified between research and the practice of bereavement therapy.

The aim of this thesis is to examine a relatively new and under researched approach to the treatment of grief, namely the use of Acceptance and Commitment Therapy (ACT). It is proposed that this approach could provide an empirically sound model on which therapists could base their interventions.

Method: Firstly a conceptual review examines the key components of ACT and their applicability to grief work. Secondly, a qualitative piece of research uses interpretative phenomenological analysis to explore the lived experiences of both therapists and clients who have used the approach.

Results: The conceptual review finds a good degree of fit between the components of the ACT therapeutic model and the needs and aims of bereavement work. The qualitative study provides preliminary support for the application of the model in the treatment of grief, indicating positive experiences for both therapists and clients particularly in its valuing of the individual nature of grief, its ability to put suffering into a positive context and its strength in dealing with emotional and thought related issues.

Implications: The thesis provides a theoretical underpinning and an exploration of practice in the treatment of grief which may be useful for therapists considering a new approach to grief work or those developing services for the bereaved.

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He always encouraged my academic endeavour and has continued to inspire me by his example ever since.

Give sorrow words: the grief that does not speak

Whispers the o'er fraught heart, and bids it break.

Shakespeare W. *Macbeth*. Act IV, scene III, line 98.

Chapter One: Introduction.
Thesis Structure, Overview, Literature Review & Rationale.

1.1. Structure of the Thesis

This introductory chapter serves to introduce the thesis and the topic. The thesis comprises two main elements; a conceptual literature review (chapter two) and a study (chapter three). The conceptual literature review was written for publication with the aim of increasing interest and discussion of the Acceptance and Commitment Therapy (ACT) model on which this thesis is based; as such it is subject to a stringent word limit. Therefore, before the main literature review the introductory chapter will present and discuss some background concepts that are necessary to the reader's understanding. The thesis comprises:

Chapter One, *Introduction*: *Structure of the Thesis, Overview, Literature Review & Rationale* which includes some background information on the topic of grief and bereavement, provides the first part of a two part literature review and presents the rationale for the research. It begins by introducing the psychology of death and explaining common terms used within this specialism. It also includes additional background literature from the most influential theories of grief, and introduces the basics of the ACT model; it provides a detailed critique of research and the origins of ACT, which are relevant to the thesis.

Chapter Two, *The application of Acceptance and Commitment Therapy principles to bereavement therapy: A conceptual review,* discusses relevant literature in the area of bereavement and looks at the fit between the ACT model and current

understanding of the processes of grief. The goal being to provide a useful theoretical underpinning to aid therapists who adopt this approach.

Chapter Three, *The Experiences of Therapist and Bereaved Clients of using an Acceptance and Commitment Therapy approach to grief work: An interpretative phenomenological analysis,* presents a study into the application of ACT for bereavement. The research aim was to qualify how aspects of the therapeutic process were related to the grief experience and adjustment to the loss. It presents the first hand experiences of six therapists and two bereaved clients.

Chapter Four, *Thesis Discussion and Conclusion,* brings together the preceding chapters by summarising the conclusions of the conceptual review and the key findings of the research report. Implications for counselling psychology practice are also discussed along with limitations of the present study and a number of suggestions for future research.

Chapter Five, *Critical Appraisal of Research Process,* concludes the thesis with a personal account of the research process through the discussion of the development of the research proposal, obstacles encountered, learning and achievements, and future prospects.

1.2. Overview

Death is an inevitable event in an individual's life. For the majority this comes in late adulthood. However, death can occur throughout the lifespan, from the earliest of deaths occurring through miscarriage and stillbirth, through to childhood illness, adult illness and accident, suicide or crime. For the majority though, death is

a natural process occurring in old age as a result of inevitable decline (primary aging) and environmental influences, such as health behaviours, social class and disease (secondary aging).

According to the office for National Statistics, in England and Wales there were 493,242 recorded deaths in 2010; almost one death every minute of each day. Each of these deaths in turn, impacts on the life of others or on society. With so many affected by grief and loss, providing adequate support for those who need it, is being taken very seriously by those professionals who come into contact with and offer services to the bereaved.

1.3. Understanding Death

The meaning attributed to *death* changes throughout the lifespan, with younger children having difficulty in understanding the finality and irreversibility of death (Slaughter & Lyons, 2003). Lansdown & Benjamin (1985) found that children began to understand the permanence of death around age nine, although children who had experienced death within their families were likely to understand at a much earlier age (Stambrook & Parker, 1987). During the adolescent years, young adults display a unique invulnerability, believing that bad things only happen to others and often overestimate their own life expectancy (Snyder, 1997). This avoidant way of thinking is conversely accompanied by an increased fear of death (Abengozar, Bueno, & Vega, 1999). By middle age, understanding goes further than acceptance of finality, inevitability and universality, to include the changes in relationships within a family or for an individual (Boyd & Bee, 2006).

Yalom (2008) suggests the gift of self-awareness which makes us human, brings with it the realisation of our own mortality and this knowledge in turn affects

the unconscious mind of every human being. Our unique capacity for social construction means death has evolved in complexity issue consisting of biological, psychological, spiritual, societal and cultural components (Kastenbaum, 2000). Throughout history, death has been depicted as terrifying through its personification as dark, hooded figures, reaping the living (the Grim-reaper or angel of death) and is usually depicted as male although in some eastern European cultures, Death is depicted as female. The ancient Greeks however, saw Death as not purely evil and portrayed him as a bearded, winged man. Thanatos (death) was seen to be male, whereas life female. In Buddhist and East Asian mythology, Yama is a wrathful God said to judge the dead and preside over his kingdom of hell or Purgatories and the cycle of rebirth. It is easy to see how the social construction of death has led to it becoming something which was feared, spoken about little and faced up to only when we had to. Wong (2010) however, talks of a change in attitudes, suggesting that our constant bombardment with images of death through news media, film, games etc. has led to a new willingness to face our own mortality and contributed to a growing interest in the issue for psychological research in this area.

1.4. Defining Bereavement, Grief and Mourning

Bereavement is commonly defined as being deprived of something, especially by death, and grief is defined as the experience of sadness or sorrow (e.g. Lindemann, 1944; Worden, 1982). Mourning is the 'social face of grief' an expression of such sorrow, which is culturally defined in terms of a set of behaviours in which the bereaved are expected to participate. Although customs vary between cultures and evolve over time, they remain present. Behind some of the theories of bereavement is the idea that, as humans, we have the tendency to make strong, long

lasting attachment bonds with others, beginning with the first interactions with our primary caregiver (Bowlby, 1961). Grief is then a natural, instinctive reversal of this process. This process of grief has been said to follow a predictable pattern (Bowlby, 1961; Parkes, 1972). It is widely accepted that in order to adjust the bereaved must confront and express intense emotions; Freud first termed this Grief Work (1917). Parkes (1996) argues that a growing neglect of formal mourning traditions has led to a decrease in support for bereaved individuals, both from society and their families.

1.5. Models of Grief

Most bereavement therapy is based on stage models, which involve the progression through distinct phases, (Bowlby, 1961; Kubler-Ross, 1969; Parkes & Weiss, 1983). The most well-known of these is Kubler-Ross's (1969) model which comprises of five successive stages:

i. Denial – this is usually a temporary defence, it can be a conscious or unconscious refusal to accept facts.

ii. Anger – once in this second stage the individual is said to recognise that denial cannot continue. Anger can be felt towards self or others.

iii. Bargaining - this third stage involves the hope that the individual can somehow postpone or delay the inevitable.

iv. Depression - during the fourth stage, the person begins to understand the reality of the situation. Because of this, the individual may become silent, refuse visitors and spend much of the time crying and grieving. This process, it is suggested, allows the person to disconnect from their loved one.

v. Acceptance - In this last stage, individuals begin to come to terms with their loss and there is said to be a degree of detachment.

The above hypothesis was originally derived for people suffering from a terminal illness. The stage models proposed by Bowlby (1961) and Parkes and Weiss (1983) set out to describe the process of mourning as seen in adults responding to bereavement. There is some similarity in the terminology found in both models. Bowlby (1961), proposes four stages: Shock and numbness, Yearning and Searching, Disorientation and Disorganisation, and finally Reorganisation and Resolution. Whilst Parkes and Weiss (1983) propose: Shock, Alarm and Numbness, Pangs of grief- pinning, Depression, disorganisation and despair and finally Recovery. Both models describe a longing and compelling need to search for the lost one which involves looking for signs and signals that the person is still nearby, or visits to places of significance to the deceased as if trying to find them, both Bowlby (1961) and Parkes (1969) postulate that this is a regular feature of grief and by no means abnormal.

Critique of such models has arisen from the exceptions that have been found (Wortman & Silver, 1989; Bonanno, Wortman & Lehman, 2002). Wortman and Silver (1989) conclude that the usual description of grief as a series of predictable stages is simplistic and possibly misleading. As such it could lead a person to feel guilty if they do not experience the predicted uncontrollable grief described as present in the months following bereavement. Additionally a person who reads that the initial shock is supposed to wear off after 10-14 days may feel abnormal if acute grieving lasts much longer than that. The authors' results show that failure to experience uncontrollable grief immediately after the death and extended grieving are indeed common. One assumption of the stage models is that grief ends, however Peppers and Knapp (1980) recognised recurrent grief occurring among parents who had lost a child. They noted bereaved individuals experienced episodes of renewed

grief after a period of assumed recovery and also reported worsening of grief over time, even after they had experienced their grief as less intense. This notion of 'recovery' and what this actually means has also been questioned. Zisook and Schuchter (1985) found that although dysphoric feelings and behaviours were most prominent during the first year, they continued to be present four years after the death. Maciejewski, Zhang, Block & Prigerson, (2007) argued for an empirical evaluation of the stages in their own right and set out to test whether the normal course of adjustment following a natural death moved through stages of disbelief, yearning, anger, depression, and acceptance. They concluded from their longitudinal study, that counter to the stage theory, following a natural death yearning was the predominant distressing sentiment throughout (1-23 months post-loss). Although grief measures indicated peaks for disbelief, anger and sadness, in the sequence proposed by Bowlby (1961) and Parkes (1972), the indicators were highly correlated with each other and acceptance was found to increase throughout the 23 month period, rather than occurring as a final stage.

Worden (1982; 1991) formulated a slightly different model to the previous stage models. He classified the vast repertoire of grief experiences under four categories; emotional response, physical sensations, altered cognitions, and behaviours. In his 'task model' of grieving he proposed that the process of mourning requires the bereaved to undertake four tasks, and unlike the stage models these do not have to occur in any specific order:

Task One – to accept the reality of the loss.

Task Two- to work through the pain of grief.

Task Three- to adjust to an environment in which the deceased is missing.

Task Four- to emotionally relocate the deceased and move on with life.

Worden's ideas became prominent in counselling and therapy programs developed for the bereaved (Stroebe & Schut, 2010). The idea of working through grief (known as "grief work," following Freud, 1917/1957) was a fundamental notion underlying the development of both the stage and task models.

Stroebe and Schut (1999) identify several short comings of the stage models and so-called 'grief work hypothesis', including failure to explain the dynamic process of grief, gender differences, lack of empirical evidence and cross cultural variations. Instead they theorise that one moves back and forth between different stages of grief, rather than moving progressively through them. Their 'Dual Process Model' (DPM) introduces the idea that whilst it is important to express emotions, at times it could be beneficial to control them. They suggest that healthy grieving involves moving between these two states. During the emotional avoidance stage focus is placed on solving practical issues. One of the most important features of this model is that it provides an alternative to the view that grief is resolved solely through confrontation with the loss (Archer, 1999). Whilst it is clear that there are always practicalities involved in adjustment to a loss and new circumstances it is difficult to see how this could be applied in the therapeutic setting. Specifically the decisions about when to contact the emotional pain, at what point to suppress it, and when to return again.

To test the assumptions of the DPM, Shear, Frank, Houch & Reynolds (2005) designed an intervention program (complicated grief treatment, CGT) which involved describing the model to bereaved clients with an emphasis on the need to undertake restoration as well as loss tasks. They evaluated the efficacy of this program against interpersonal psychotherapy (IPT). They found the DPM based intervention to be more effective than IPT, and suggest these are promising results in

support of the model. Both treatments produced improvement in complicated grief symptoms, response rate (defined either as Clinical Global Improvement score of 1 or 2, or a 20-point or better improvement in the self-reported Inventory of Complicated Grief) was greater for complicated grief treatment (51%) than for interpersonal psychotherapy (28%; $P = .02$) and time to response was faster for complicated grief treatment ($P = .02$). This was the first randomised control trial of CGT delivered according to a manual protocol, and whilst results were promising the response rate was still only 51%, indicating more work is needed.

1.6. Attachment and the Role of Self in Grief

Bowlby's attachment theory (1969,1980) has played an important part in shaping some of the current ideas on 'grief work', it talks of rearranging representations of the lost one and in turn, of the self; the end result being envisaged as a breaking of the bond with the deceased (Bowlby, 1980). Attachment to the deceased has been theorised to be a predictor of outcome following bereavement (Bowlby, 1980; Sanders, 1989 and Stroebe, 2002) and may result in different patterns of grieving. Mikulincer, Shaver & Pereg (2003) argue that attachment-related strategies of affect regulation arise as a result of different patterns of interactions with significant others. Those individuals who are more psychologically enmeshed with the deceased are at greater risk of problems associated with grief, due to their beliefs that they are unable to cope without that person because they have been reliant on them for emotional security. In support of this idea, Jerga, Shaver and Wilkinson (2011), observed more intense grief among people who describe themselves as having been more strongly attached to the spouse they have lost. Aron & Aron's (1986) self-expansion model explains that when individuals form

romantic relationships, their own sense of self assimilates attributes and qualities of their partner. Lower perceived self-competency following loss of a spouse has been reported in those marriages of long duration (Carr & Boerner, 2009; Romo & Zettel-Watson, 2009; Van Doorn, Kasl, Beery, Jacobs, & Priegerson, 1998). The marital quality hypothesis assumes that adjustment to loss is associated with the quality of the marital relationship. However there is some disagreement here, Parkes and Weiss (1983) argue that conflicted marriages experience the most severe grief, whilst Fraley and Shaver (1999) propose it is those in close marriages who have more complicated grief experiences.

Retrospective attachment styles, in the sense that they are developed in childhood and adolescent attachment experiences, have been found to play a mediating role in how individuals process grief (Fraley & Shaver, 1999; Parkes, 2002/2001, 2006; Shaver & Tancredy, 2002). Bowlby (1980) argued that grief processing, psychological distress, and grief oscillation are mediated by the coping preferences of the individuals due to the attachment style established in childhood. Wayment and Vierthaler (2002) also explored the association between attachment style and reaction to bereavement, in 91 adults (21 men & 70 women) they found individuals who reported having a closer attachment to the deceased, and had a more sudden loss, reported greater levels of grief. Individuals with an anxious-ambivalent attachment style reported greater levels of grief and depression, whilst those with a secure attachment reported less depression. Because our relationships with intimate others provide validation through shared memories (Landfield, 1988) the loss of these relationships undermines our very identity (Neimeyer, 2000b). This provides support for treatment to be tailored towards correcting maladaptive perceptions of the self, and creating a more positive self-representation. Frantz, Farrell, and Trolley

(2000) have noted the pervasiveness of this type of personal reconstruction in the lives of bereaved adults, and reported that in the year following a loss 32% viewed themselves as more mature and independent, with 17% living more fully in the present, they also reported being more compassionate and expressive with others. However a minority also acknowledged regressive shifts in their sense of self, noting that a part of them had died (10%), that they were more fearful of death (5%), or were hardened by the experience (5%).

The idea that the purpose of grieving was to 'break the bond' with the loved one to enable new attachments to be made has been challenged and more recent thinking suggest that it is indeed the opposite, it is to allow a continuation of the bond, all be it in a different form (Klass et al, 1996, Walters, 1996; 1998). In support, Fraley and Shaver (1999) argue that continuing bonds can and do exist.

1.7. Mortality and Bereavement

Bereavement has long been associated with poor health outcomes, and a number of studies have looked at the mortality of bereavement itself. Grief has been likened to both physical (Engel, 1961) and mental illness (Kendler, Myers & Zisook, 2008; Prigerson et al., 1997). When Holmes and Rahe (1967) asked 394 participants to rate the amount of social readjustment required for a range of putatively stressful life events, death of a spouse was ranked, on average, as the most stressful. Mellstrom, Nilsson, Oden, Rundgren & Svanborg, (1982) found a highly significant increase in death rates amongst widows during the three months following bereavement and amongst widowers in the first year. Stroebe, Stroebe & Hansson, (1993) reviewed fifteen longitudinal studies and concluded that not only were the

widowed at greater risk of dying when compared to the non-bereaved, but that the risk also increased for other relatives. They also noted that risk was highest in the early weeks and months, and that men are more susceptible than women. Martikainen and Valkonen (1996) reported mortality was very high for accidental and violent causes and alcohol-related diseases, moderate for chronic ischaemic heart disease and lung cancer, and small for other causes of death. This supports the earlier findings of Mellstrom et al. (1982) in respect of increased risk of accident, and those of Jones and Goldblatt (1987) in respect of deaths by violence. Stroebe & Stroebe (2007) conducted a review of studies they considered to be well-controlled for confounding variables in which they looked at the health outcomes of bereavement; they too concluded an association with an increased risk of mortality, including suicide. The increased risk of suicide has also been supported more recently in research by Ajdacic-Gross et al. (2008). Bereavement has been found to increase the risk of depression, physical illness, suicide, heart disease & to contribute to psychosomatic and psychiatric disorders, with up to a third of people suffering the loss of a spouse or a child, being affected (Parkes, 1998). It has also been associated with high blood pressure (Prigerson et al., 1997; Prigerson & Jacobs, 2001), cancer (Prigerson et al., 1997), cardiac events (Prigerson et al., 1997), and serious mental health outcomes (Horowitz & Siegel, 1997; Raphael & Martinek, 1997). Longitudinal research (Bonanno, Wortman & Nesse, 2004) suggest that bereavement related difficulties can be present for many subsequent years following the loss.

Bereavement has been associated with negative health outcomes and as such it is important to identify those most likely to be affected in order to target appropriate support towards them. Such far reaching effects for the bereaved provide further evidence that this psychological process deserves further research.

1.8. Individual Differences in the Grieving Process

1.8.1. Mourning Styles

A distinction has been made between mourning styles. Historically, the failure to exhibit grief following bereavement has been viewed as an indication that the grieving process has gone awry (e.g., Marris, 1958), a number of studies have found suppression of grief to be harmful (Bonanno, & Kaltman, 1999; Stroebe & Schut, 1999) leading to delayed and distorted grief. On the other hand excessive grieving has been associated with chronic grief and depression (Raphael, 1975; Shear, Zuckoff, & Frank, 2001; Stroebe, Hansson, Stroebe, & Schut, 2001). Middleton, Moylan, Raphael, Burnett, & Martinek (1993) conducted a survey of clinicians and researchers in the field of loss and found a majority (65%) endorsed the belief that "absent" grief exists, that it typically stems from denial or inhibition, and that it is generally maladaptive in the long term.

Maciejewski et al. (2007) argue that it is of clinical importance to identify typical grief symptom trajectories to enhance the understanding of cognitive and emotional processes, thus enabling those who fall outside this to receive appropriate treatment. They were the first to suggest that grief indicators were not always in decline six months after the loss, and it is these individuals who are thought to be at greater risk of long term adverse effects following bereavement and who could be described as suffering from 'complicated grief'.

1.8.2. Complicated Grief

Complicated grief is distinct from normal grief. It has been proposed as a diagnostic category in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 Development, 2012) produced by the American Psychiatric Association as an adjustment disorder with clinically significant symptoms related to bereavement and specified as:

> "Following the death of a close family member or close friend, the individual experiences on more days than not intense yearning or longing for the deceased, intense sorrow and emotional pain, or preoccupation with the deceased or the circumstances of the death for at least 12 months (or 6 months for children). The person may also display difficulty accepting the death, intense anger over the loss, a diminished sense of self, a feeling that life is empty, or difficulty planning for the future or engaging in activities or relationships. Mourning shows substantial cultural variation, therefore the bereavement reaction must be out of proportion or inconsistent with cultural, religious, or age-appropriate norms."

With such varying responses being reported following bereavement, an awareness of individual differences is vital so that any interventions offered to those grieving, be flexible enough to meet their specific needs.

1.9. Does 'Grief Work' Work?

Silver and Wortman (1980) argue that the common concept of 'working through one's grief' could be detrimental to recovery. This notion of 'grief work' is vague and therefore the theoretical and empirical evidence could be said to be lacking in clarity and application (Stroebe, 1992; Stroebe & Schut, 2010).

Neimeyer (2000) goes as far as to report deterioration effects in grief counselling, concluding that "nearly 38% of recipients of grief counselling theoretically would have fared better if assigned to the no-treatment condition" (p 545). The results for 'normal grievers' – those considered to not be 'traumatically bereaved' was even more worrying, "nearly one in two clients suffered as a result of treatment" (p. 546). However, Larson and Hoyt (2007) have criticised the acceptance of these findings as fact, after Neimeyer's original frequently cited (2000) article was re-examined and found to be based upon an unpublished, statistically questionable dissertation. A more thorough quantitative review of research on grief interventions was conducted by Allumbaugh and Hoyt (1999). The authors incorporated both pre- and post-treatment scores from both treatment and control groups in their meta-analysis, this allowed for a comparison of change over time (rather than simple post treatment scores), thus quantifying the extent of natural recovery observed in the reviewed studies. This is particularly relevant to bereavement as it is usually expected for symptoms to somewhat abate over time as part of a natural processes (Bonanno, Wortman, et al., 2002). They conclude that there is no strong empirical foundation that clients are harmed by counselling and indicate a cautious optimism with regard to empirical findings on grief counselling outcomes.

Neimeyer and Currier (2009) also set out to identify how effective such interventions are, alongside identifying who can benefit most and looking at the aspects of grief which could be targeted. Again they state that there is no conclusive evidence from their substantial reviews of the literature which included group therapy, individual and family work, psychotherapy, counselling, narrative therapy, support groups, and social activity groups, they found only weak to moderate effect sizes in favour of grief interventions. They did however find encouraging results in

favour of interventions offered to the bereaved who were suffering prolonged and intense symptoms. Importantly, Neimeyer and Currier (2009) found that timing is not a significant moderator for outcome, along with sex, age or relationship to the deceased. They conclude that grief therapists should have an appreciation of the resilience and adaptiveness of the majority of bereaved clients, and should target interventions to those who are substantially clinically distressed in accordance with the evidence base which highlights more optimistic outcomes in such circumstances.

1.10. Summary

- Grieving and mourning have been conceived as the processes whereby the bereaved person adjusts to the reality of their loss, enabling them to disengage from the deceased and reinvest in new relationships. Bowlby's attachment theory (1969-80) and Parkes (1972) psycho-social transition theory offer *psychological* models of bereavement, allowing predictions regarding the outcome of an individual's bereavement process (Parkes, 1993).
- Since the publication of Kubler-Ross's seminal book *On Death And Dying* in 1969, stage models of grief have predominated in therapeutic practice. The model describes stages through which a person who is bereaved should move through sequentially. Potentially a person could get 'stuck' at any stage, impeding their movement to the next stage and thus obstructing 'resolution' of their grieving process. The resulting expectation of what is considered 'normal' regarding bereavement, gives rise to 'risk factors' that predict a greater likelihood of 'complicated bereavement' and even diagnoses of 'pathological, unresolved, grief'.

- Such orthodox theories are now being challenged by empirical evidence and modified according to new understanding in the human sciences and in therapy. Assumptions regarding healthy outcomes are seen as one possibility among many, and not to be imposed universally upon the experience of all bereaved people. Emphasis is not placed on the resolving of grief or closure, but on renegotiating the meaning of loss over time (Klass et al., 1996; Walters, 1996; 1998; Fraley & Shaver, 1999).
- Bereavement has been associated with negative health outcomes and as such it is important to identify those most likely to be affected in order to target appropriate support towards them.
- Research into the effectiveness of grief interventions has been inconclusive and has been criticised for being vague both in terms of the interventions used, and in its theoretical and empirical evidence. Much of the research has been carried out on specific populations e.g. widows, psychiatric patients.

Through this review, it is apparent that there is a need to develop further ways of working therapeutically with individuals in bereavement therapy. The current models do not answer to all of the experiences encountered in bereavement therapy. For example, traditional 'grief work' has been accused of failing to focus on positive outcomes (Stroebe & Schut, 2010) despite the evidence that positive growth can be achieved (Tedeschi & Calhoun, 1995). Furthermore, existing approaches have struggled when there is conflict between problem focused and emotion focused coping styles (de Ridder, 1997). Successful bereavement therapy requires an approach which recognises the individual nature of grief, is able to offer interventions to deal with emotional, cognitive and practical aspects of grief and then set this within a positive framework which can encourage hope for the future.

A gap has also been noted between theory, research findings and practice. This paper attempts to address this by reviewing ACT theory, suggesting how this might be applied to practice and then finally exploring how this is working in practice.

I will now introduce the approach I am suggesting might address some of the issues previously mentioned.

1.11. Introducing Acceptance and Commitment Therapy

Acceptance and Commitment therapy (ACT; Hayes, Strosahl & Wilson, 1999) offers a profound approach to the issues of why human life and the search for happiness is such a struggle. In essence it has two objectives, the fostering of an acceptance of unwanted private experiences which are out of personal control and the development of committed action towards living a valued life. The ultimate goal is to increase psychological flexibility. A key component of the ACT model is mindfulness.

1.11.1. Mindfulness

Mindfulness has been defined as "the clear and single-minded awareness of what actually happens to us and in us at the successive moments of perception" (Nyanaponika Thera, 1972, p. 5); "keeping one's consciousness alive to the present reality" (Hanh, 1976 p. 11) and in ACT literature this is described as "paying attention with flexibility, openness and curiosity" (Harris, 2009, p. 8). Harris (2009) suggests that three important factors are relevant in an understanding of mindfulness. Firstly, it is not a thinking process. Secondly it necessitates an attitude of openness and curiosity. Finally it requires the flexibility to consciously direct focus on all

aspects of a particular experience. Brown and Ryan (2003) question whether mindfulness is a naturally occurring characteristic; they state that whilst most everyone has the capacity to be aware, we should not assume that it is a readily available resource for all. Individuals can differ in their ability and inclination to be aware and to sustain attention to what is occurring in the present. Rumination, preoccupation with the past, and thoughts of one's future can draw awareness away from what is happening in the present moment. Mindfulness can also be inhibited by preoccupation with multiple tasks or worries which diminish the quality of awareness of the present experience (Deci & Ryan, 1980).

The first psychological intervention to incorporate mindfulness training was Jon Kabat-Zinn's Mindfulness-Based Stress Reduction programme (MBSR) introduced in 1979 (Kabat-Zinn, 1982). This programme aims to train participants to approach their experiences with an attitude of mindfulness developed through daily practice of meditation which focuses attention on the breath, sensations in the body, or the senses, bringing the focus of attention to the present moment. A number of randomized controlled trials have demonstrated the efficacy of this approach (see review by Fjorback, Arendt, Ornbøl, Fink, & Walach, 2011).

Mindfulness is becoming increasingly popular and has been applied to a range of psychological and life issues. It is now incorporated into Cognitive Based Therapy (Baer, 2003) and is an integral part of Acceptance and Commitment Therapy. The role of observant, open awareness and attention in the optimization of self-regulation and well-being (see reviews in Brazier, 1995; Martin, 1997) has long been seen as important in many schools of psychotherapy. To this extent, mindfulness represents an evolution of therapeutic technique, not a revolution. Brown and Ryan (2003) argue that psychoanalytic tradition uses free association,

which represents a receptive awareness hovering over the psychological landscape (e.g. see Freud, 1912/1963). In humanistic approaches, awareness is thought to enable the identification of needs, conflicts, and existential concerns (Rogers, 1992). In the Gestalt tradition (Perls, 1973), healthy organism was seen as forming clear and vital Gestalts or perceptions that emerge in states of relaxed attention. Wilber (2000) proposes that once previously alienated, ignored or distorted aspects of experience are recognised they can be transcended, and integrated into the self.

1.11.2. The Hexaflex and the Core Therapeutic Processes of ACT

The primary aim of ACT is to promote psychological flexibility. ACT refers to psychological inflexibility as the source of psychopathology. Psychological flexibility is found at the centre of the ACT Hexaflex (see fig 1 below), surrounded by the inter-connecting core processes.

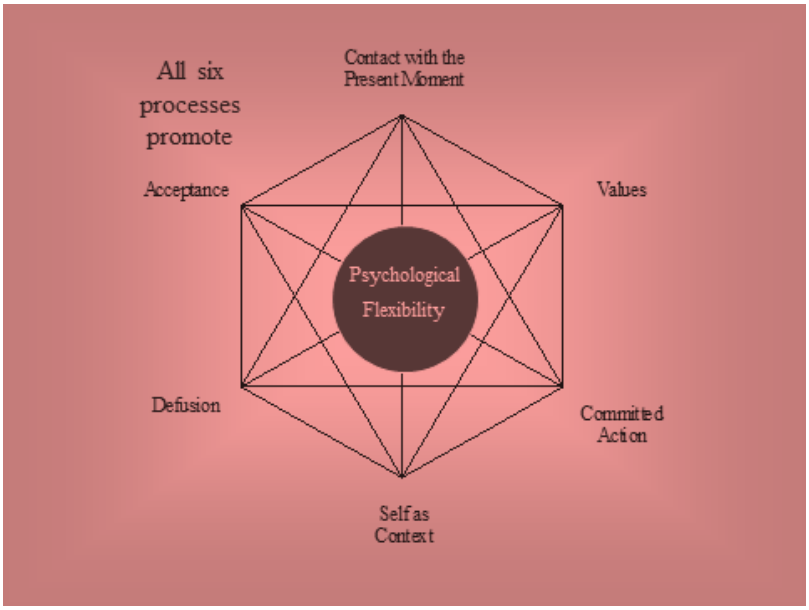

Figure 1. The ACT Hexaflex.

Although there are six individually named processes, there is substantial interconnection between them. The six processes can be seen as forming into two

groups, acceptance and mindfulness processes (contact with present moment, acceptance, defusion & self as context) and commitment and behaviour change processes (values & committed action). The goals of ACT are summarised in the acronym:

1. Accept thoughts & Feelings.

2. Choose actions.

3. Take action.

Whilst the hexaflex illustrates that these processes are all connected and support each other, there is no set order in which they should be targeted, this is based upon the individual needs of each client (Hayes et al., 2005; Strosahl, Hayes, Wilson, & Gifford, 2004). A more detailed description of these concepts and how they relate to bereavement therapy appears in the conceptual paper which follows (Chapter 2). Consequently, the assessment of individual differences in psychological flexibility has been a central focus of ACT research. A generic self-report measure of psychological flexibility, the Acceptance and Action Questionnaire (AAQ) has been developed for this purpose (Bond et al., 2009; Hayes, Strosahl et al., 2004), resulting in the latest form of this instrument, the AAQ-II (Bond et al., 2009). Numerous studies have found significant mediation effects between psychological inflexibility as a result of experiential avoidance, cognitive fusion, attachment to the conceptualised self, dominance of the conceptual past and future, lack of values and inaction, impulsivity or avoidant persistance (e.g. Kashdan & Breen, 2007; Orcutt, Pickett, & Pope, 2005), thus signifying the importance of psychological flexibility.

1.12. How successful is ACT?

In 2001, Corrigan argued that new behavioural therapies, such as ACT were "getting ahead of their data" (p.189). He postulated that ACT along with eye movement desensitisation and processing (EMDR), dialectical behaviour therapy, (DBT) and functional analysis psychotherapy (FAP) are viewed as prominent because of the success of their textbooks and their inclusion in behavioural journals. Corrigan (2001) based his argument on a database search in October 2000. He found 17 studies, only 2 of these being randomised control trials, and there were no randomised control trials for therapists. Corrigan acknowledges that using just one source to collect the data does limit his findings, but he argues it shows how the writing up of 'claims of the intervention' is being presented rather than actual empirical findings.

In reply, Hayes (2002) insists that it is "no small matter" (p.134) to criticize behavioural therapies in this way. He argues that ACT is grounded in empirical evidence and that Corrigan's (2001) argument is based on publication counts alone. Indeed it does seem unfair to judge a new emerging therapeutic approach by counts obtained through a limited search. In defence of ACT, Hayes (2002) replies to some of the concerns raised, suggesting that Corrigan has not spent enough time reading the actual articles; instead suggesting he has made a mere judgement on the claims of the researcher. It is argued that this is "intellectually shallow" (p.135) and it is important to consider the strength of the findings rather than the claims of the author. Peterson and Park (2010) argue that the current academic culture interprets complexity as significance. A well conducted study should allow the reader to make a decision based on statistical evidence rather than relying on the author's claims of its effectiveness, or the complexity of its design. Corrigan argues that it is the ratio

of empirical to non-empirical papers that is the problem. However, all new ideas must begin from somewhere, and the ACT revolution may be part of a paradigm shift (Kuhn, 1962). Hayes (2002) cites evidence to support that using a comparison of empirical/ non-empirical research would mean most modern physics and biology is ahead of its data (e.g. the theory of relativity was 90% non-empirical). Hart and Hogan (2003) also argue that we will never try anything new if we base our practice only on empirical, evidence based interventions. Gaudiano (2009) notes that typically any emerging psychotherapeutic approach experiences limitations in its early RCT's. To date no single approach has been shown to be systematically and routinely more effective than another (Roth & Fonagy, 2005). Hayes (2002) says "number crunching is not enough to build a discipline" (p.136).

When Corrigan (2001) unleashed his attack on the so called 'third wave behavioural therapies', the ACT approach was only some 2 years old, therefore this argument seems somewhat harsh and now dated. Since this early criticism of the claims being made by ACT devotees, research is growing fast, and by 2002 Hayes (2002) claimed that it is at twice the level reported by Corrigan. It is true that much of this research has been conducted by Steven Hayes, who is the originator of the approach; therefore it could be seen as being presented in a biased fashion in favour of the program, and this is perhaps what Corrigan (2001) is implying. However, whilst Hayes is determined to validate ACT empirically as its development was so strongly grounded in his early research, when looking through the growing number of research papers one actually sees a considerable number of researchers presenting their work in the field from a global perspective.

Reviewing the literature again in 2006, Hayes and colleagues report on the use of ACT across what they called 'an unusually broad range of problems' from

psychosis to worksite stress, and refer to correlational evidence about experiential avoidance, experimental psychopathology and ACT components studies, randomized trials, and process of change studies. Whilst accepting it is difficult to get large scale studies up and running, due to financial restrictions and available client pools, the authors reported that ACT was superior to control conditions, wait-lists and treatment as usual (TAU) (*d*= .99 at post-treatment and *d*=.71 at follow-up) and superior to structured interventions (*d*= .48 at post-treatment and *d*= .63 at follow-up). A strength of ACT appears to be its breadth of applicability, it is hoped this could be replicated in grief work.

Further critique of ACT was reported by Ost (2008), who conducted a review on methodology and a meta-analysis on efficacy to determine if the so called 'third wave' treatment RCT's fulfilled the criteria for empirically supported treatments. In the ACT category he reviewed 13 RCT's and concluded that they used a research methodology that was significantly less stringent than CBT studies; that the mean effect size was moderate for both ACT and DBT, and that none of the third wave therapies fulfilled the criteria for empirically supported treatments. In reply to this Gaudiano (2009) conducted a re-analysis of this review and recognised that, although Ost noted several important limitations that should be given careful thought when evaluating early ACT research, his attempt to find comparable CBT studies produced mismatched samples, with differences in populations, study design and methodology. Gaudiano (2009) goes on to criticise the non-reporting of clear differences in grant support in favour of CBT. A further meta-analysis review of ACT empirical evidence in RCT's concluded that ACT is better than wait-list and placebo conditions but not significantly better than established treatments (Powers, Zum Vörde Sive Vörding, & Emmelkamp, 2009). However, Levin & Hayes (2009)

have now re-analyzed the database reported by Powers *et al.* (2009) concluding that ACT was better than established treatments.

Notwithstanding these conversations over the precise degree of empirical support for ACT, it is gaining clinical support. For example, the British Association for Behavioural and Cognitive Psychotherapies has recently established an ACT special interest group. ACT is now considered to be an empirically supported treatment on the American Psychological Association Division 12 list of empirically-based treatments (APA, 2012) with moderate support in depression and strong support in pain. ACT could conceivably prove to be a valuable form of therapy in the future, indeed if its popularly continues to grow, along with ever expanding research, this may well be the case. Hayes's resolution to keep it empirically based must surely be, along with the (although limited) promising outcomes so far, be fuelling increased interest and support for the approach. It is indeed common, and should not be seen as a slur, for new approaches to receive opposition from those embedded in their current ways of practice. Yet, Cullen (2008) suggests that the high amount of interest in ACT may be due to earlier forms of CBT being "found wanting" and suggests that clinicians are favouring more sophisticated approaches.

The cry for therapies to become recognised as evidence-base practices (EBP), originating primarily from a research environment has attracted some criticism and appears to be the main criticism of ACT. Randomised control trials, according to Margison et al. (2000) are poor at predicting outcomes for individual clients and Stewart & Chambless (2010) argue that clinicians rely more on clinical judgment than on research findings. As therapists it may be preferable to view practice as 'research- informed' rather than 'research-directed', as Westen, Novotny and

Thompson-Brenner (2004) propose. Here, research is seen as very valuable but not exclusive, with theory, personal experience and supervisory input also having a role to play. This stance would place greater value on some of the real world case studies which have so far emerged in favour of ACT.

1.13. Rationale for the present work

To date, bereavement work is based on psychological models which are not very prescriptive, do not account for individual differences and lack an evidence-base. As such they offer little guidance to the therapist.

ACT may provide a useful theoretical underpinning to aid therapists thinking of adopting new ways of working with bereavement (see chapter 2). To this end, the purpose of this thesis is firstly to review the ACT model, and the evidence for it, and to establish the degree of fit with the usual aims of grief work.

There has been little written specifically about bereavement from an ACT standpoint, and yet avoidance, lack of contact with the present moment, fusion with stories about the deceased and the self, loss of valued direction and lack of committed actions are common for people following bereavement. Traditional 'grief work' has been accused of failing to focus on positive outcomes (Stroebe & Schut, 2010) and yet there is evidence that positive growth can be achieved (Tedeschi & Calhoun, 1995). Importantly ACT is able to address commonly reported aspects of bereavement which include not only the emotional distress and longing, but also the thinking of the past and future, practical changes and problems such as lack of income, changing roles, with a central goal of psychological flexibility which emerges as the new self. Other approaches have struggled when there is conflict between problem focused and emotion focused coping styles (de Ridder, 1997).

ACT work uses experiential exercises and metaphor to contact the self as a secure sense of oneself which is separate from events which may have occurred, and in doing this decreasing attachment from a world of words and their implied meanings.

Anecdotally, counsellors who use ACT approaches in their general work tend to employ ACT methods in grief work within their practices, but there have been, to the best of my knowledge, no studies examining the effectiveness of ACT for these purposes, despite its apparent suitability. It would therefore be beneficial to investigate how these methods are being employed, to systematically explore clinician experiences of their effectiveness and discover any particular aspects of the ACT model which are useful. This could hopefully provide some guidance for therapists, and offer an alternative to current approaches. Therefore the second aim of this thesis is to explore the ACT models application in this area with an initial study.

It has been argued that research approaches which are aimed at developing our understanding of therapy but fail to address the client's interpretation of events can provide only a limited picture of its true nature (Gordon, 2000). To address this issue the empirical study reported in this thesis will explore both the therapists' and the clients' experiences. Both these perspectives (clinical expertise and client characteristics, values and context) are seen as making a valuable contribution to the development of evidence based practice (American Psychological Association; APA, 2002). Psychological services are said to be most effective when they are responsive to the client's specific problems, strengths, personality, sociocultural context, and preferences (APA, 2002). Researchers have also been criticised for creating the gap between research and practice by selecting to study phenomena they know or which is relatively easy to study rather than that which is important to the

conduct of psychotherapy (Greenberg, 1986). Whilst randomized control trials (RCTs) have become the 'gold standard' of psychotherapy research they are often criticised for their limited clinical relevance (e.g. Seligman), for using treatment manuals which are too inflexible, and for failing to capture change in ways which are clinically meaningful (Westen, Novotny, & Thompson-Brenner, 2004). To that end, an inductive approach has been taken, using Interpretative Phenomenological Analysis, which aims to understand the experiences of both participants groups as they themselves understand them, with the aim of providing clinically relevant results.

In summary, the purpose of this thesis is to review the theoretical fit between bereavement work and the ACT model (Chapter 2), and then further explore the ACT models application in this area (Chapter 3).

The conceptual paper which follows, suggests how ACT might be implemented for grief work.

Chapter Two

The material presented in this chapter was initially prepared for submission to the journal '*Death Studies'*

(see appendix L for author guidelines).

The Application of Acceptance and Commitment Therapy Principles to Bereavement therapy: A Conceptual Review.

2.1. Abstract

Acceptance and Commitment Therapy (ACT) offers a profound approach to the issues of why human life is such a struggle. Whilst the majority of people adjust after short period of distress, for others bereavement can result in serious consequences for their physical and emotional well-being. Accepting the pain that life can bring, ACT promotes a search for existential meaning and fulfilment. ACT aims to encourage valued directions for each individual, in full acknowledgement of the presence of negative personal events. It argues that psychological inflexibility and its resulting behaviour can hinder progress towards current goals and values.

Research into the efficacy of current bereavement interventions has produced inconclusive results and has highlighted the failed link between the practice of bereavement therapy and research findings. This paper proposes that Acceptance and Commitment Therapy (ACT) could be used to address some of the short comings of current bereavement work and outlines the application of this theory to practice. The paper concludes that there is an appropriate fit between the ACT therapeutic model and the aims of bereavement therapy. It provides a theoretical underpinning for those therapists wishing to learn about the ACT model and begin integrating these techniques and approaches into their existing practice.

2.2. Keywords: grief; bereavement; acceptance and commitment therapy; psychological flexibility

Current models of bereavement therapy have been criticised as lacking an empirical basis, and failing to recognise the individual nature of grief, not least because so many therapeutic models in this field rely on stage theories of bereavement (e.g. Bowlby, 1961, Kubler-Ross, 1969; Parkes & Weiss, 1983). Such models have themselves seen theoretical critique (e.g. Stroebe & Schut, 1999) and an attack from empirical studies that fail to support their central tenets (Bonanno, Wortman & Lehman, 2002; Wortman & Silver, 1989). In light of such criticism, many bereavement therapists are looking for novel psychological models and therapeutic approaches, based in sound empirical evidence of effectiveness.

This paper will begin by taking a brief look at the history of bereavement theory and the development of several stage models aiming to depict the process of grief. Emerging new models and theories are then discussed leading up to an introduction to the proposed theoretical model of this paper, ACT. The six core processes of the ACT model are then applied to typical aspects of grieving and discussed in relation to bereavement and broader literature. The conclusion sums up the potential for such principles to be applied to bereavement therapy.

2.3. The Origins of Bereavement Research

Since Freud first termed the phrase “Grief work” in 1917, bereavement has been seen as a process of adjustment, during which the bereaved must face and express intense emotions. Early research into bereavement resulted in the development of several stage models, which describe the progression through distinct phases (Bowlby, 1961; Kubler-Ross, 1969; Parkes & Weiss, 1983).

Despite wide spread acceptance for stage models and their use within the medical community for all aspects of loss, Maciejewski, Zhang, Block, Prigerson,

(2007) argued that these models have never been empirically supported. Several empirical studies have indeed found exception to the stage model (Bonanno, Wortman & Lehman, 2002; Maciejewski, Zhang, Block & Prigerson, 2007; Wortman & Silver, 1989). Such models, whilst attempting to classify the process of grieving, could never account for the great variations of grieving found both individually and cross-culturally. They provide little assistance to the grief therapist beyond the recognition of typical grief reactions, they tend to pathologize grief, and place grievers in a passive role.

In an attempt to address the individual nature of grief, Stroebe and Schut (1999), introduced the 'Dual Process Model of Coping with Loss', which encompasses traditional ideas of working through grief (Freud, 1917; Lindermann, 1944) with recognition of additional stressors placed upon the individual in terms of adjustment to life changes. The model acknowledges the dynamic nature of grief, oscillating between loss-oriented and restoration-oriented work.

2.4. New Models for Treatment

With the questioning of long-held assumptions about the trajectory of grief (Bonanno, 2004; Wortman & Silver, 2001) comes the emergence of new models and theories which reflect a shift in thinking from purely intrapersonal to interpersonal, from clinical to biopsychosocial and from descriptive accounts to recognising mediating factors. For example, cognitive-behavioural conceptualisations of complicated grief (Boelen, van den Hout, van den Bout, 2006; Neimeyer & Gamino, 2006) and Rubin's (1999) 'Two-Track Model', which focuses both on the biopsychosocial functioning of the bereaved and on their on-going processing of their changing relationship to the deceased. Research has also advanced in line with

new thinking (see Parkes & Prigerson, 2009; Stroebe et al. 2008). Drawing from this, new treatment models are being developed such as Complicated Grief Therapy (Shear, Frank, Houch & Reynolds, 2005), narrative interventions (Lichtenthal & Cruess, 2010), and family focused grief therapy (Kissane & Bloch, 2002). Although some of these approaches have been tested in random controlled trials with promising findings, Currier, Holland and Neimeyer (2010) question their real effectiveness when the researchers have a strong allegiance to their particular paradigm.

There is an evolving interest in compassion and mindfulness-based interventions (Cacciatore & Flint, 2012; Rushton et al, 2009) which have been shown to moderate long-term, negative psychiatric consequences for both therapists and clients. Cacciatore & Flint (2012) propose a model (ATTEND) which they claim fosters healing and post traumatic-growth. The acronym, ATTEND, stands for (A)ttunement, (T)rust, (T)herapeutic touch, (E)galitarianism (N)uance, and (D)eath education. The model relies on the therapists' *attunement*, which is achieved through an emphasis on mindfulness, responsiveness, empathy, and self-awareness. Aspects of the model are then integrated into the therapeutic relationship and the client is encouraged to practice mindfulness themselves. The authors propose this model allows providers to be aware of the individual nature of grief and provides a more sane and compassionate framework of bereavement care. Rushton et al.'s (2009) "Being with Dying: Professional Training Program in Contemplative End-of-Life Care" (BWD) is again based on the development of mindfulness and receptive attention through contemplative practice, in order to encourage stability of mind and emotions, which in turn allows clinicians to respond to others and themselves with compassion.

Despite the use of mindfulness-based therapies for a wealth of psychological issues such as anxiety (Koszycki, Benger, Shlik, & Bradwejn, 2007), depression (Kenny & Williams, 2007), and insomnia (Heidenreich, Tuin, Pflug, Michal & Michalak, 2006), the concept has not been well disseminated within the bereavement therapist community.

2.5. The Efficacy of Current Bereavement Services

Services now commonly offer bereaved people the chance to join groups or receive one to one counselling. However, Parkes (1996) has criticised such groups for employing models derived from psychiatric settings which have the danger of implying that the client is in some way sick (Parkes, 1996). It has even been suggested that insensitive support can actually intensify emotional hurt, and increase confusion and unwillingness to move on with life (Ingram, Jones & Smith, 2001; Melham et al., 2004). Attempts to empirically validate such work have provided inconclusive results to date, for example, Lieberman & Yalom (1992), assigned mid and late-life bereaved spouses to a brief group psychotherapy intervention or a control group. The study had hypothesised that brief group psychotherapy during the early stages of loss would facilitate adjustment, particularly for the more psychologically distressed, however only modest improvement on role functioning and positive psychological states were found, with no differential reported for the highly distressed group.

The distance between research findings and actual grief workers has been argued to be a possible reason for poor outcomes in grief therapy, with front-line workers still following traditional and unsubstantiated ideas (Jordan & Neimeyer, 2003). Neimeyer (2000) suggests also that the lack in clarity of grief interventions

used in outcome studies shows the distance between grief researchers and therapists, he calls for more collaboration to produce a more clinically relevant science.

This paper gives an example of how such bridges could be crossed with the proposed integration of a new empirically based approach into the practice of therapists working with this client group.

2.6. What is Acceptance and Commitment Therapy?

Acceptance and Commitment therapy (ACT; Hayes, Strosahl & Wilson, 1999) is often referred to as one of the third wave behavioural therapies. It derives ultimately from the radical behaviourism of Skinner (1953; 1969; 1974) and its behaviourist roots are often seen as off-putting by therapists of a more person-centred orientation. Skinner demonstrated that humans could construct linguistic stimuli that would then gain control over their behaviour in the same way that external stimuli could. This stance meant that the likelihood of reinforcement producing the same effect on human behaviour as it did on animals was slight. Steven Hayes and colleagues, who developed Acceptance and Commitment Therapy, first developed a theory of human learning called Relational Frame Theory which aims to provide a model for the development of human language, and to explain the power language, including verbal thoughts, has to elicit emotional responses (Hayes, Barnes-Holmes & Roche, 2001a; Hayes & Hayes, 1989). ACT is based directly on RFT and thus provides a model that is at once theoretically and philosophically coherent, and empirically supported.

ACT is based on the concepts of value driven actions, which are used to guide and inspire mindful change. Whilst accepting the pain that life can bring, it promotes a search for existential meaning and fulfilment (Fallon, 1992; Harris, 2009;

Kvale & Grenness, 1967; Plumb, Stewart, Dahl, & Lundgren, 2009). ACT stipulates that most psychological problems fall into one of the following categories: Experiential avoidance, Cognitive fusion, Contextual control, the Solution is the problem and Value action is the goal (Hayes and Pankey, 2002), which will be explained in more detail later. ACT aims to encourage valued directions for each individual, in the context of negative personal events. It argues that the verbal significance of an individual's evaluation, in both a literal or social context can lead to psychological inflexibility (Luoma, Hayes & Walser, 2007), and as a result behaviour is inconsistent to current goals and values because of environmental controls. Human language provides us with a continuous awareness of verbal connections and cognitive building blocks which can be both inspiring and troublesome.

ACT accepts feelings, states of mind and introspection as existent and scientifically treatable, and sees them as non-dualistic; it does not accept that feelings are the cause of behaviour. This approach is in direct opposition to that of Cognitive behavioural therapy (CBT). For instance, distancing oneself from thoughts, emotions and beliefs (a CBT strategy) influenced by Beck (1976) was found to exacerbate them in some clients (Hayes & Melancon, 1989). Carrascoso Lopez (2000) argued that a radical behaviourist approach such as ACT is more beneficial than training in additional avoidance skills (CBT). Indeed he argues that focusing therapeutic effort on thoughts and physical sensations (i.e. hyperventilation), a typical CBT approach, may be hiding the aetiology of panic in patients with anxiety. Culturally, an emphasis is placed on 'feeling good' and avoiding negative emotion or pain, in this way ACT moves against the dominant model of western psychology by shifting the focus away from symptom reduction.

ACT literature argues that avoidance of aversive internal stimuli, such as undesirable emotions, can increase the functional importance of such emotions, consequently behaviour is then restricted to prevent evoking uncomfortable private events (Hayes, Luoma, Bond, Masuda & Lillis, 2006). In other words, despite telling ourselves it is not good to focus on hurtful, anxiety provoking thoughts, they still occur and we engage much effort into trying to avoid unavoidable truths.

Although ACT is relatively new, its development has emerged from a strong empirical framework. Early trials on Comprehensive Distancing (Zettle & Hayes, 1986) and Relational Frame Theory (Hayes, Barnes-Holmes, & Roche, 2001) have been utilised to shape the development of ACT. With its origins emerging from the standpoint that human language is at the root of human suffering, the ACT model considers the 'mind' to be a complex set of related cognitive processes relying on language which act upon us from internal and external sources. This 'mind' or cognition can be both useful and destructive and is often referred to as both a blessing and a curse (Harris, 2009, p7). Despite the pain that humans inevitably suffer throughout their lifetime, the 'mind' itself has the power to produce painful feelings, reproduce painful memories, and predict uncertain futures. It is the aim of ACT to teach a new way of coping with this pain through Mindfulness.

The concept of mindfulness has roots in Buddhist and other contemplative spiritual traditions and religions. Both ACT and Buddhist philosophies hold that suffering is a ubiquitous part of human existence and that our constant struggle with thoughts, emotions and behaviours in the search of happiness is the root of this suffering (Hayes, 2002). Mindfulness itself is becoming increasingly popular in Western psychology. It is seen as an actively cultivated process whereby conscious attention and awareness are focused on what is taking place in the present moment. It

has been defined as “the clear and single-minded awareness of what actually happens to us and in us at the successive moments of perception” (Nyanaponika Thera, 1972, p. 5); “keeping one’s consciousness alive to the present reality” (Hanh, 1976, p. 11) and in ACT terms is described as “paying attention with flexibility, openness and curiosity” (Harris, 2009, p. 8).

2.7. Applying ACT Principles to Bereavement

In ACT, psychological flexibility emerges from six core processes. It is important to note that these are not separate entities; they work alongside each other to achieve a common goal. A therapist may choose to work on any number of core processes, interweaving them as they are activated by client material (Luoma, Hayes & Walser, 2007). The first four core processes show how the ACT approach utilizes the principle of mindfulness.

2.7.1. Acceptance

A willingness to fully experience troubling, uncomfortable thoughts, feelings and sensations. An ACT based approach would encourage the client not to shy away from contact with the pain of loss. The approach would argue that conscious deliberate avoidance of private events is unlikely to be successful when the event itself is unchangeable. No amount of emotional control can undo the loss or change an event (Hayes, Strosahl & Wilson, 1999). Attempting to conceal thoughts and feelings has been shown to increase their frequency and intensity (Wegner & Zanakos, 1994). Focussing excessively on controlling negative experiences eventually becomes emotionally and physically draining and leaves little energy and self-control for other demanding tasks (Baumeister, Gailliot, DeWall, & Oaten, 2006). Stroebe and Schut (2010) also talk of the great effort involved in trying to

deny or avoid the pain associated with grief. As grief is a natural process, it would therefore seem sensible to use an approach which would facilitate experiencing this emotion rather than avoiding it. If not addressed correctly, avoidance of situations which evoke distressing memories about the deceased could lead to a restricted lifestyle and hinder full recovery. Many cultures place certain expectations upon grievers to keep emotions under control, even when in the company of their own family, by setting time periods, by only allowing grieving to take place in private (Wikan, 1988), or by dictating male or female differences in the expression of grief (Martin & Doka, 2000). Such strongly held beliefs can be present in the therapy room and could hinder traditional modes of grief work which focus on the explorations of thought, emotions and memories in order to relinquish attachment from the deceased, by not actively encouraging the full experience of emotion. Bonanno (2009) argues that traditional grief work ignores the role of positive emotions, and the power of phenomena such as laughter in recovery. Hayes et al. (1999) acknowledge that when moving in a new direction is difficult due to psychological distress, being willing to experience the pain, to stop resisting it and to allow it to come and go of its own accord, allows for a real understanding of what is actually happening, rather than our minds telling us what the experience says. Experiencing this pain is crucial. Reflection, 'staying in the here and now' and 'giving permission' can facilitate this by encouraging the opposite of experiential avoidance. Whilst reflecting upon, observing and sharing emotions in the safety of the 'here and now' clients are encouraged to make full, undefended, psychological contact with their private experiences. Encouraging clients to give themselves permission to be as they are in the moment, facilitates an active, positive, non-

passive experience which is not about succumbing to distressing emotions but about a willingness to experience and accept them.

2.7.2. Cognitive Defusion

Defusion is used in this sense to mean an undoing of 'fusion'. It refers to the way language can often be seen as more than just a word and given meaning which we feel impelled to act upon. ACT encourages the recognition of troubling thoughts without the need to take them as describing reality perfectly. ACT uses experiential exercises and metaphor to contact the self as a secure sense of oneself which is separate from events which may have occurred, and in doing this decreasing attachment from a world of words and their implied meanings. ACT uses mindfulness as a metacognitive form of awareness, allowing for a shifting of cognitive sets that open up the possibility for alternate appraisals of life events.

The nature of the attachment relationship to the deceased has been proposed as a possible predictor of outcome and grieving style following bereavement (Bowlby, 1980; Sanders, 1989; Stroebe, 2002). Attachment theories postulate that those individuals who are more psychologically entwined with the deceased, that is those who, due to their beliefs that they are unable to cope without that person because they have been reliant on them for emotional security, are at greater risk of problems associated with grief (Mikulincer, Shaver & Pereg, 2003). MacCallum and Bryant (2008) looked at self-defining memories in bereaved individuals (*N=40*) with and without complicated grief (CG), and found that CG participants provided more self-defining memories involving the deceased, which suggests an association between autobiographical memory and self-identity. They offer this as a cognitive explanation as to why on-going dependency and attachment occurs in grieving individuals who experience on-going yearning for their loved one when they view

their self-identity as more closely linked to the deceased. An ACT therapist may tackle this issue through the use of defusion techniques such as repeating words until their literal meaning fades (Hayes & Smith, 2005). Clients often use troubling psychological content as an excuse for not acting in a values driven way or for avoidance. Therapists encourage the use of the word 'and' to replace words such as 'but' and 'because', this affords the client more options for meaningful action as opposed to private events being taken as valid reasons for not acting (Eifert & Forsyth, 2005). Particularly relevant to grief work is the way clients may fuse to stories of their past, leaving them stuck or unable to move forward (Zettle, 2004). Yearning for the deceased has been found to be associated with painful memories (Raphael & Martinek, 1997); such memories may play some part in maintaining complicated or prolonged grief. 'Over general memory' has been identified in complicated grief (Golden, Dalgleish & Mackintosh, 2007) and is associated with diminished problem solving ability and inability to imagine the future. The ACT therapist would not dispute facts from within a client's life story but would focus on exploring what purpose this story serves now. It is suggested that this can reduce the control such stories can have over client's behaviour (Hayes & Smith 2005; Zettle, 2007).

2.7.3. Being Present

ACT postulates that when we are fully aware in the present moment we are more flexible and open ourselves up to wider possibilities, as opposed to being stuck in the past. Mindfulness is used as a way of developing this awareness. Rumination, preoccupation with the past, and thoughts of one's future can draw awareness away from what is happening in the present moment. Mindfulness can be inhibited by preoccupation with multiple tasks or worries which diminish the quality of

awareness of the present experience (Deci & Ryan, 1980), which are often found in grief. ACT employs methods such as mindfulness of the breath, an object, or eating to bring clients awareness to the present moment, the 'here and now', with a conscious awareness of their inner psychological world and their surroundings.

Most bereavement therapy is based on the person-centred approach (Rogers, 1951) and the integration of models of grief, which foster self-exploration and reflection. Both Parkes & Weiss (1983) and Worden (1982) suggest that grief therapy involves a moving towards being able to 'be' with the person rather than be able to 'do' something to alleviate the distress. Whilst this has been seen as appropriate due to the idiosyncratic nature of grief reactions (Barbato & Irwin, 1992; McLaren, 1998), it has been argued that the approach has no observable technique to move clients beyond the expression and acceptance of negative emotions (Gilliland & James, 1998). Although ACT cannot take away the pain, by allowing for a gentle holding and understanding, it can guide resilience and post-traumatic growth (Farb et al., 2007; Siegel, 2010) through the use of mindfulness techniques. Russ Harris (2007, p.156) uses Leo Tolstoy's quote to explain "There is only one time that is important – NOW ! It is the most important time because it is the only time that we have any power"

2.7.4. Sense of Self (self as context)

In ACT terms there are three sense of the self; *self as content* (the conceptualised self), *self as awareness* (noticing/observing) and *self as context* (the perspective/locus/space from where observing happens, the 'you' that observes). Because the term *self as context* can be confusing it is also sometimes known as the observing self or self as perspective. Whilst our conceptualised self (*self as content*) is dominated by our beliefs, thoughts, ideas, images, judgements and memories, and

our *self as awareness* is our physical self, *self as context* lies beyond these and is a place from where our other selves can be observed. As such, *self as context* is a stable, enduring, safe self which is not defined by any thought, feeling, emotion, memory or experience and is less prone to verbally attached meanings. For instance, feelings of regret or guilt which may lead a person to define themselves as "bad" or "selfish", (Flaxman, Blackledge & Bond, 2011, p.29) which can often increase distress (Harris, 2007).

Research has found that individuals who experience on-going yearning for their loved one tend to view their own self-identity in a manner more closely bound to the deceased (MacCallum & Bryant, 2008). Self-defining memories are an essential factor in developing an internalized life story (Sutherland & Bryant, 2005) and the degree in which an individual is able to adjust their self-identity following bereavement, is linked to recovery after a loss (Parkes & Weiss, 1983). This adjustment involves changes in life roles and the disruption of attachment relationships. Self-representation has been found to influence autobiographical memories recalled by the bereaved (Conway, Singer & Tagini, 2004). Individuals with complicated grief symptoms exhibit more self-defining memories which contain reference to the deceased; it appears they define the deceased as part of themselves and have difficulty in defining themselves as an individual.

Typically, clients are unaware that their stories about themselves are not the same as their actual experiences (Luoma, Hayes & Walser, 2007). Work might focus on helping the client to see the content within their concept of self, and the functions this may have. This could be useful when clients feel they must express their grief in a certain ways to fit with their conceptualised self. Experiential exercises can also foster the understanding that although ones felt experience is constantly changing,

the sense of consciousness itself does not. Metaphors such as 'The sky and the weather' below taken from Harris, (2009, p175) or the Chessboard (Hayes et al., 1999, p. 190-192), can also assist in explaining the concept to clients.

> *Your observing self is like the sky. Thoughts and feelings are like the weather. The weather changes continually, but no matter how bad it gets, it cannot harm the sky in any way. The mightiest thunder storm, the most turbulent hurricane, the most severe winter blizzard – these things cannot hurt or harm the sky. And no matter how bad the weather, the sky always has room for it – and sooner or later the weather always changes. Now sometimes we forget the sky is there, but it's still there. And sometimes we can't see the sky- it's obscured by clouds. But if we rise high enough above those clouds – even the thickest, darkest, thunderclouds- sooner or later will reach clear sky, stretching in all directions, boundless and pure. More and more, you can learn to access this part of you: a safe place inside from which to observe and make room for difficult thoughts and feelings.*

Once a client is able to observe and connect with this continuous sense of self they are more able to respond in a flexible manner and are not stuck or fused with troubling past memories or evaluations.

The last two processes define the ACT approach to behavioural activation.

2.7.5. Values

Feeling that life holds no meaning, and social withdrawal, are symptoms commonly found in bereavement, and also identified within complicated grief

(Prigerson et al. 2009). It has been suggested that therapies which promote a sense of competence and hope for a satisfying and productive future are most beneficial to such central issues in those with complicated grief (Prigerson, 2004). ACT aims to encourage a sense of on-going awareness through the identification of values that are personally important. This is essential in creating meaning in life. Hayes et al. (1999) defined values as "verbally construed global desired life consequences" (p.206), they are what we stand for. Values are seen as ways of behaving and are not outcome variables. Therapists work to clarify ways of behaving which are desirable within the values context and promote a desire to act rather than a need to. Such values should be individual and not culturally defined, thus ensuring a real sense of purpose and meaning within the client. Hayes et al. (1999) offer an example of how values differ from goals when comparing "getting married" and "being loved". The desire to be 'loving and caring' is an on-going value which you can continue to act on throughout your life; however, getting married is a goal, something which can be achieved even if you neglect your values. In this way values are more empowering as they are more than just targets, they offer a choice which is always available to us in the here and now. When a client is widowed or becomes a widower, they may lose the physical presence of that partner, and obtain a new label, but enabling them to see that they have not lost the values they once held strongly could be a source of comfort to them with the realization that not everything has changed, what is important may still exist within them. This realisation can see meaning and hope emerge from painful times and encourage re-engagement in life. Therapists can also use the experienced pain to illicit values exploration, for instance, by asking, what the pain says about what really matters, who matters, what you are reminded of, can this pain be your ally,

what can it teach you? Again the responses give clues to the values which once drove the client to action, and once recognized they can be key to committed action.

2.7.6. Committed Action

A commitment to action for achieving the personal values identified. In this stage a therapist may employ more traditional methods to achieve goals as defined by the client's values, for instance, activity scheduling, exposure and homework assignments (Eifert & Forsyth, 2005). ACT encourages the client to pursue valued behaviours whilst using mindfulness and acceptance skills to cope with difficult private events which they may experience. At this point goals can be selected with the aim of moving the client in a valued direction even if this involves eliciting undesirable thoughts and feelings. There are plenty of values, goals and actions forms available in the ACT literature (Eifert & Forsyth, 2005 p.218, 244; Harris, 2009 p.221; Hayes and Smith, 2005 p.181-183), but the important thing is for the client to track their progress in a format which engages them. Clients will undoubtedly encounter external and psychological barriers which may threaten valued living, but ACT sees this as another opportunity for exploration and further development. For bereaved clients pressures can come from lack of skills, money, other family members, social circles and cultural influences, with assumptions about how the grieving should behave (Gorer, 1965; Kastenbaum, 2000; Miller & Turnbull, 1986; Wortman & Silver, 1989). Feelings of guilt may be present if the client pursues any activity which might bring enjoyment. ACT would see this as making room for new things whilst still holding true to personal values.

2.8. Conclusion

There has been little written specifically about bereavement from an ACT standpoint, and yet avoidance, lack of contact with the present moment, fusion with stories about the deceased and the self, loss of valued direction and lack of committed actions are common experiences for people following bereavement (e.g. Deci & Ryan, 1980; MacCallum & Bryant, 2008; Prigerson et al. 2009; Wegner & Zanakos, 1994) and are related to poorer outcomes.

There seems to be a good degree of fit between the ACT therapeutic model and the needs and aims of bereavement work. This paper has provided a theoretical framework for such interventions and aims to help practitioners to adopt ACT in their practice.

Counsellors who use ACT approaches in their general work tend to employ ACT methods in grief work within their practices, but there have been no published studies examining the effectiveness of ACT for these purposes, despite its apparent suitability. It would therefore be beneficial to investigate how these methods are being employed, to systematically explore clinician experiences of their effectiveness and discover any particular aspects of the ACT model which are useful. In the meanwhile, bereavement therapists may wish to learn about the ACT model and begin to integrate some of its techniques and approaches into their existing practice.

Chapter Three

The material presented in this chapter is broadly consistent with the guidelines for authors of the journal '*Psychology and Psychotherapy: Theory, Research and Practice* ' excepting its length, as required by the stipulations of the professional doctorate course.

(Small additions have also been made to in-text citations, to draw the reader's attention to other parts of the thesis where appropriate.)

The Experiences of Therapist and Bereaved Clients of using an Acceptance and Commitment Therapy approach to grief work: An Interpretative Phenomenological Analysis.

3.1. Abstract

Rationale. Current bereavement work lacks a strong theoretical and empirical base and fails to answer all of the experiences encountered in bereavement therapy. Acceptance and Commitment Therapy (ACT) may provide a much needed theoretical underpinning to grief interventions and is now beginning to be applied in this area.

Objectives. The aim of this study was to gain deeper understanding of the topic through the exploration of the therapists' and clients' sense of their experiences of ACT when used for grief work.

Design. Data were collected via semi-structured interviews.

Method. Six therapists and two bereaved clients took part in the study. The data were analysed using Interpretative Phenomenological Analysis.

Results. Interviews with the Therapists produced four emergent super-ordinate themes: Facing grief with ACT; Factors shaping application; Why therapists choose to use ACT; and The purpose of Theoretical Knowledge.

Interviews with the bereaved clients produced three super-ordinate themes: The presence of undesirable thoughts and feelings; Client perceptions of the therapeutic process; and Adapting to life without the deceased.

Conclusions. ACT has been found to be useful by both therapists and clients. Key areas identified included intrapersonal benefit for therapists, coping strategies for strong emotions experienced by clients, acceptance and positive adjustment following bereavement.

3.2. Introduction.

Death has been described as the single universal event which affects all of us on many varying levels (Yalom, 2008). The unique human ability for meaning-making and social construction denotes a complex and dynamic arrangement involving biological, psychological, spiritual, societal, and cultural components (Kastenbaum, 2000). Although there is a proportion of individuals who are able to accommodate their loss and return to a 'normal' level of functioning (Lindemann, 1944; Neria & Litz, 2003), there is a subset (between 10% to 20%) who experience significant functional limitations from their traumatic loss (Neria & Litz, 2003). It is these individuals who would most benefit from intervention.

Elisabeth Kubler-Ross (1969, 2009) has been credited for introducing death as an important area for research and medicine (Wong, 2010). Her stage-model of grief has been very influential in thanatology circles. The model identifies defence mechanisms as present in the psychological reaction to death (denial and bargaining), negative emotional responses (anger and depression) and finally acceptance. However, this model has been widely criticized on two levels. First, not every individual follows a predictable pattern in the resolution of their grief. Bonanno (2009) reported that most people can come to death acceptance without struggling through the previous stages. Second, it has been argued that there is no

empirical research to substantiate the idea of progression through a set of stages (Maciejewski, Zhang, Block & Prigerson, 2007).

More recent models accept a less rigid process as occurring. The dual process model (Stroebe & Schut, 1999) recognises that people oscillate between processing the loss and adapting to a changed life. Rubin's (1999) 'Two-track model', incorporates biopsychosocial functioning and processing of an evolving on-going relationship with the deceased.

Such prevailing models have been criticised for being inaccurate, incomplete and biased. There is little or no empirical research to substantiate their accuracy. Where data have been published, they have tended to be collected from specific populations e.g. widows or psychiatric patients (Piper, Ogrodniczuk, Azim, Weideman, 2001). Whilst these models have dominated the field of grief therapy, they have failed to provide guidance to therapists who are seeking a better understanding of the process and individual nature of grief and who value empirically sound treatment plans.

There is increasing demand within the National Health Service (NHS) for therapeutic interventions to be regulated and consequently emphasis is placed upon evidence-based practice. The National Institute for Clinical Excellence (NICE) recommends treatment plans in accordance to what works best (Roth & Fonagy, 2005) based upon effectiveness.

In an attempt to address these issues, treatment models are now being developed which reflect new thinking and some have been evaluated in randomised control trials, seen as the 'golden standard' of EBP. One such is Shear et al.'s (2005), 'Complicated Grief Therapy' (CGT), this uses the dual process model to develop accommodation of the loss and encourage restoration of roles and life goals. The

former found that after 16 sessions, CGT was more effective than interpersonal psychotherapy for complicated grief symptomatology, however both groups showed improvement. A meta-analysis of CBT based grief interventions reported their general efficacy, but again it was unclear whether they were more effective than other therapies (Currier, Holland & Neimeyer, 2010). The effectiveness of narrative therapy was examined by Lichtenthal and Cruess (2010) in a controlled trial which reported significant improvements in depressive and PTSD symptoms in a group who were writing about positive life changes. Whilst these new treatment models are attempting to provide new solutions there is a clear need for the development of a therapeutic approach to grief that is both based in sound theory and enjoys a considerable empirical evidence base and this paper explores one such possibility, the application of Acceptance and Commitment Therapy (ACT) principles to grief therapy.

Evidence- based practice (EBP) is defined by Sackett et al. (1996) as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available clinical evidence from systematic research. The goal of EBP is the integration of: (a) clinical expertise/expert opinion, (b) external scientific evidence, and (c) client perspectives to provide high-quality services reflecting the interests, values, needs, and choices of the individual. Greenhalgh (2010, p. 163) points out that qualitative research ''is not just complementary to, but in many cases a prerequisite for… quantitative research…''., and that concepts and treatment models for EBP are routinely developed and refined using qualitative research. Qualitative research is said to enhance EBP by helping researchers understand how and why interventions

work, by identifying new variables and hypothesis for future research, by clarifying unexpected results and by improving the accuracy and relevance of quantitative research (Black, 1994). Popay and Williams (1998) add that qualitative study allows professionals to understand the experience and meaning of being a client and can explore the impact of treatment on clients, as such the views of clients can be seen as determing effectiveness (Petr, 2009). It has been argued that research approaches which are aimed at developing our understanding of therapy but fail to address the client's interpretation of events can provide only a limited picture of its true nature (Gordon, 2000). Professional expertise and the personal experience of the professional also deserve conceptual elaboration and further study as part of EBP (Gilgun 2005).

Most therapists and researchers would agree that the measurement for successful adjustment following bereavement is marked by an acceptance of the reality of the loss and a re-engagement in life (Balk, 2004; Corr, Nabe & Corr, 2003). The core message of Acceptance and Commitment Therapy (ACT) is to accept what is out of our personal control, while committing to action that will improve quality of life. It has been proposed that ACT could be an effective therapeutic model to use for grief work (Walker, Hulbert-Williams, & Nicholls, 2012; see chapter two). The theoretical underpinnings of ACT (Hayes, Strosahl & Wilson, 1999), the current evidence base (Levin & Hayes, 2009; Ruiz, 2010) and its possible application to grief work (Walker, Hulbert-Williams & Nicholls, 2012; see chapter 2) have been reviewed extensively elsewhere. This material is not repeated here for reasons of space.

3.2.1. Aims

The key aims of this research were to examine the experiences of both therapists and clients when ACT is applied to grief work. The personal lived experiences of both groups were examined with the aim of understanding at a deeper level how the model was being applied and how the clients responded to the approach. The research was looking to qualify how aspects of the therapeutic process were related to the grief experience and adjustment to the loss.

3.3. Methodology

3.3.1. Choosing qualitative research

ACT specifically for bereavement is not taking place on a large scale, therefore using any quantitative methods for this research has been discounted on the basis of insufficient numbers. Qualitative approaches are particularly good for studying complexity, novelty and processes (Smith, 2008). The study aimed to focus upon gaining an idiographic understanding of participant's experiences, and of what ACT means to them, within their social reality (Bryman, 1988). It focuses on a limited number of individuals in order to obtain richer knowledge and greater depth of understanding. Such an understanding has the potential to be used both by practicing Psychologists to inform process and those concerned with developing grief services. In exploring both the therapists' and the clients' experiences this study was designed to add to the evidence base for grief interventions by providing insight into the important aspects of EBP: Clinical expertise/expert opinion and Client perspectives.

3.3.2. Rationale for using Interpretative Phenomenological Analysis (IPA)

In order to understand in greater detail the lived experiences of the participants in this study, the qualitative research method, Interpretative Phenomenological Analysis has been selected. IPA is particularly suited to explore expectations and experiences within homogenous groups of participants (Brocki & Weardon, 2006; Smith, 2008). Semi-structured interviews are most commonly used in IPA studies as these represent a good balance between the researcher's aim to gain relevant information and the participant's freedom to express their most important experiences. This person-centred approach allows the participant to explore their own narrative, sharing an experience that cannot be achieved by the use of other methods such as questionnaires.

According to Lyons and Coyle (2007), this type of qualitative analysis is particularly suited to issues that are emotive and dilemmatic, involving reflection. This study falls into that category. Eatough and Smith (2006) suggest that rather than concentrating on how individuals 'do emotion' instead of how individuals 'be emotional' reduces lived experiences to social activity and nothing more. Using interpretative phenomenological analysis allows for private, psychologically powerful aspects of individual thoughts and beliefs, which can be indefinable in normal terms, to be identified. This hermeneutic approach recognises that social influences play a part in individual's linguistic practices, but declares that an individual's world consists of more than social process alone (Martin & Sugarman, 1999; Biggerstaff & Thompson, 2008). IPA is concerned with both the individual nature and the personal characteristics of an individual and although it accepts that there is no direct access to this information, with the help of the researcher's interpretations of the participants expression of their thoughts and beliefs, it is hoped

that a more critical understanding might be achieved. IPA recognizes the importance of the participant researcher dynamic and that meanings occur as a result of their interaction (Smith, 1996; Smith, Jarman, & Osborn, 1999). Although IPA is a relatively new method of analysis its validity has been upheld, (see Yardley, 2000; Smith, Brewer, Eatough, Stanley, Glendinning & Quarrell 2003) and it is gaining in popularity in the psychological sciences (Brocki & Wearden, 2006).

3.3.3. Ontological and epistemological positions: reflexivity

As a Counselling Psychologist this approach has a number of attractive qualities. Willig (2001) argues that the methodology chosen by researchers should be congruent with their own philosophy. Reflexivity is a big part of my own therapeutic practice and personal development and as McLeod (1994) suggests we are constantly engaged in 'research' during our clinical practice. Bager-Charleson (2010 p. 125) talks of the researcher's identity being "a crucial factor in what they can illuminate", much as it does in therapy. To this end any research will reflect an element of the researcher themselves.

3.3.4. Interview schedules

Two semi-structured interview schedules were developed for use in this research study (see Appendix C & D). The interview questions evolved to elucidate answers on the experiences of both the therapists using this approach for bereavement work and clients of working within this approach.

The semi-structured interviews were devised to allow the researcher to guide the conversation, whilst still allowing the interviewee the freedom to express themselves. Both schedules consisted of 10 open ended questions, followed by

subsidiary prompts. In line with IPA guidance (Smith, Flowers & Larkin, 2009), the aim was to collect rich, in-depth information, therefore negating the need to have a large numbers of participants; an important consideration given the small population of therapists using ACT in bereavement work. The questions were developed to initiate disclosure from the participants regarding their thoughts and beliefs surrounding bereavement and the use of Acceptance and Commitment Therapy based approaches. The researcher did not stick rigidly to these questions, as the aim was to allow the interviewee to direct the conversation. Additional questions or prompts were asked to encourage participants to expand their answers or to enable clarification of points they were making. This also enabled a more natural conversation to develop around the questions.

A pilot study was carried out by the researcher and a volunteer to test the suitability of the semi-structured interview schedule. No problems arose during the pilot study; therefore the schedule was used for the main study. The pilot study was not analysed.

The interviews were recorded using digital audio equipment to allow for exact transcripts to be produced (see confidential attachment). To address any potential for emotional upset caused by the interview, the fullest possible disclosure was included on the information sheet (see appendix G & H) and a debrief sheet (see appendix F) was prepared and given to participants with suggested contacts should they need any follow up help.

3.3.5. Participants

IPA requires much smaller sample sizes than many other methods and due to its infancy as a methodology, no prescribed sample size is yet agreed upon (Smith, 2008). Rather than aiming to generalise findings to the population as a whole, the method is used for in-depth understanding of a particular sub-sample of participants. As such, the methodology is acceptable for gaining a large breadth of information from sample sizes ranging from single case studies to over 30 participants, most studies average between 6 and 12 participants (Brocki & Weardon, 2006).

Participants were recruited via the online ACT special interest group. This allowed for global recruitment. The first 7 therapists to volunteer were selected to take part in the study. One interview was excluded from analysis as its content focused more on addiction work than bereavement. Only 2 clients came forward to take part, both were interviewed and the transcripts analysed with the view to triangulating the data. Both clients had worked therapeutically with therapists taking part in this study.

The participants are not referred to by their real names, but to give the transcripts of the conversations a more natural feel, pseudonyms have been allocated (see appendix E for writing conventions used). This also served to preserve the anonymity of the participants in accordance with the BPS code for Ethics and Conduct (2009).

3.3.6. Procedure

Participants were interviewed individually at a mutually convenient venue. Overseas participants were interviewed via Skype and one by telephone. Each was given an information sheet to read (see appendix G & H) and a consent sheet to sign

(see Appendix I). For those not interviewed in person the sheets were sent via email. The information sheet included the contact details of the researcher and explained that feedback will be available following completion of the study should they require it. It also explained the nature of an IPA study. A digital recorder was used to record each of the semi-structured interviews. As well as the main interview schedule, minimum encouragers and further prompts were used. All of these have been approved by the appropriate School ethics committee before use. The first question asked was a general one to allow the interviewee to become comfortable and allow them to feel that their own personal talk was important. Once all the questions had been asked and the participants given the opportunity to express their point of view, the tape recording was stopped. No identifiable data was held with the recording. Pseudonyms were then allocated to the participants and data transcribed verbatim from the recordings.

Interpretive phenomenological analysis began with detailed reading of the scripts. After several readings of each transcript (as per Smith and Osborn, 2003), any significant or interesting points were noted in the right hand border. Following this the left hand border was utilised to transform these points into themes or phrases. The emerging clusters were then given descriptive labels to convey the conceptual nature of the themes they contain. This allowed for transparency of the analysis, and verification by a second member of the research team (see confidential attachment).

IPA is an ideographic approach, and as such focus is placed upon the *particular*, it develops a nuanced account of similarities and differences but is not concerned with making claims at group level. Although themes were created that demonstrated connections between the experiences of each participant, the data

collected was still traceable to the individual and not lost by transformation of phenomena into numbers as in nomothetic inquiry (Smith, Flowers & Larkin, 2009).

The transcripts of the client interviews were analysed separately following exactly the same method used for those of the therapists (see confidential attachment). Bearing in mind the aims of the research, themes were collated to represent the clients' experiences. Whilst these transcripts were analysed separately from those of the therapists, there was an awareness to provide some validation through the use of triangulation.

3.3.7. Reliability & Validity

Reliability and Validity are important factors in the design, analysis and judging of the quality of results in qualitative research (Patton, 2001). Credibility, Confirmabilty, Dependability and Transferability are seen as essential criteria for Trustworthiness (Lincoln & Guba, 1985). To address credibility (the producing of a 'credible' conceptual interpretation of the original data; Lincoln & Guba, 1985, p.296) in this study, research supervisors were involved throughout the process, from initial ethics proposal, to recruitment, second validating interpretative analysis and write up. Confirmabilty and dependability in this study was achieved by systematic transparent analysis which allowed for a chain of evidence from the initial transcripts, through to notations, tables of themes and the final report (Yin, 1989).

Providing and converging data from multiple perspectives serves to provide confirmation of the validity of research findings. Triangulation is regarded by Smith and Osborn (2003) as an effective means of establishing credibility and transferability of any themes derived from the analysis. Triangulation in this study involved the bringing together of similar concepts occurring in both the therapists'

and clients' speech, and linking them to existing literature within the discussion section. Using triangulation maximises the trustworthiness of a study (Mathison, 1988).

3.3.8. Ethical considerations & approval.

It was recognised that conducting research using bereaved clients has the potential to cause distress. To this end the guidelines suggested by Parkes (1995) were adhered to. To minimise distress the clients were recruited via the therapists who had taken part in this study, and included only when the therapist felt in their clinical opinion that the client would not be put at risk. This took into account the fact the recently bereaved clients may be too distressed to understand explanations of the study or may, due to their vulnerable state, be easily persuaded to take part. These standards were upheld when a client volunteered to take part in the study but her therapist advised that she was not presently a suitable candidate and was hence not interviewed. Parkes (1995) recommends that interviewers should have sufficient training in the support of bereaved people, and as such be able to respond in favour of the needs of the participant over the research. The main researcher and interviewer conducting this study is a trained bereavement counsellor.

Following the submission of a research proposal (see appendix A), this study was approved by the Ethics Committees of the University of Wolverhampton, School of Applied Science (see appendix B). No participants were recruited via the NHS or interviewed in NHS settings.

3.3.9. Pen Portraits of the Therapists

3.3.9.1. Robert

Robert is a Clinical Psychologist working in a rural county in the United Kingdom. He has worked predominantly in the field of health psychology for the past twenty years. He is based across three settings, community work, hospice and out patients. He describes himself as originally a behavioural therapist, who then worked with CBT and became interested in mindfulness based approaches about six years ago. He was then introduced to ACT via the literature and consequently attended a training course in the USA about 3 years ago. He now applies ACT to his therapeutic practice and has set up groups which use ACT for people with cancer and other long term illnesses. This interview was conducted via Skype.

3.3.9.2. Dawn

Dawn is originally from Brazil where she graduated with a psychology degree in 1999. She went on to study a post degree in mental health. She then moved to Australia where she has lived and worked for the past four years. She was originally trained in psychoanalysis; an approach which she says was popular in Brazil. After moving to Australia she found that there was not the same level of confidence in psychoanalysis, so she trained in CBT. She also has some training in schema therapy and transactional analysis. She is employed by a service which works with grief, loss and trauma and also has her own private practice. She was introduced to ACT when she went on a training course run by Russ Harris and has been using ACT for about three years. This interview was conducted via Skype.

3.3.9.3. Katy

Katy is a Clinical Psychologist registrar, living in Australia. She has been working in helping professions for about 15 years. For the past four and a half years

she has worked in a bereavement specific service. She has been using ACT for about four years. She is also trained in CBT and describes herself as having an existential/humanistic approach. This interview was conducted via Skype.

3.3.9.4. Sam

Sam lives in the United Kingdom and began her career as a psychiatric nurse; she then trained as a cognitive behavioural therapist about 20 years ago. She was introduced to ACT about 6 years ago and now predominantly works using the ACT model. She has her own private practice and also works in London where she feels Mindfulness based cognitive therapy (MBCT) is very popular. Sam also has a teaching role, in which she predominantly teaches CBT. This interview was conducted in person.

3.3.9.5. Frank

Frank lives in the USA. He completed his doctoral degree in 1978 and then began working in an academic setting teaching undergraduate level psychology for the next eight years. He has his own private practice now and some continued involvement with academics. Frank feels strongly about his choice to be a Counselling Psychologist. He began his training in rehabilitation counselling and was then drafted into the Navy. When returning to study he chose the counselling route believing that he was more interested in the difficulties people experience in life as opposed to a more medical view of diagnosis of illness and working with symptoms. He sees psychology as a philosophical enterprise. He is well read in learning theory. When he graduated, he was influenced by the CBT movement and went on to pursue post-doctoral work in REBT. He met Steven Hayes, the originator of ACT, at an Association for the Advancement of Behavioural Therapy meeting and

began to follow his work. He has been practicing ACT since approximately 1997. This interview was conducted via Skype.

3.3.9.6. Sophie

Sophie lives in the United Kingdom. She originally worked in sales but had always had an interest in massage. She decided on a career change and then trained in massage. She realised that people were pouring out their troubles on the couch and decided to train as an Adlerian therapist in 1998. She then went on to study for a BSc in Integrative Counselling which she has just completed. Sophie also works as a volunteer for Cruse Bereavement Care. She attended an ACT training course in early 2011 and she has been incorporating the ideas into her work ever since. Sophie is a practicing meditator and has been interested in mindfulness since 1992. This interview was conducted in person.

3.3.10. Pen Portraits of the Clients

3.3.10.1. Beryl

Beryl has been bereaved by the death of her second husband, Ryan, six and a half years ago. They had been married for 36 years. They had no children of their own, but Ryan helped to bring up Beryl's daughter. Her son was brought up by her ex-husband. She has two grandchildren. Beryl has worked in palliative care as a therapist. Beryl lives in Australia and the interview was conducted via Skype.

3.3.10.2. Jim

Jim is 74 years of age. His wife died in July 2011. She had been suffering from dementia and Parkinson's disease, and was cared for in a home for the last two and a half years of her life. They had been together for 52 years and they had three children. Jim lives in Australia; this interview was conducted by telephone.

The findings from the analysis of the therapists' and clients' interviews are presented separately. Although not normally included in a paper for publication, line numbers have been included in brackets after quotes to allow cross-referencing with the transcripts.

3.4. Findings from Therapists study.

Reading and subsequent analysis of the therapists' transcripts produced four superordinate themes (see confidential attachment for annotated transcripts); these are presented under their descriptive labels along with emergent sub-themes in Table 1, and are then discussed. The full thematic charts are provided in appendix J.

Table 1. Superordinate themes and Constituent sub-themes

Superordinate Themes	Subordinate Themes	Example illustrative quote	Summary of theme
Facing Grief with ACT			
	1. Managing emotional states. 2. Dealing with intrusive thoughts. 3. Working with Guilt & Anger. 4. The role of Memories.	Katy: "*when people are really distressed, being in the moment mindfulness stuff is really helpful..*"	The presenting issues and therapeutic interventions for dealing with these.
Factors shaping application			
	1. Therapists own influence. 2. Knowing something is not living it. 3. Integrating other approaches. 4. Unique nature of each client.	Frank: *"rather than explaining choices I'd ask people to make choices…."*	What is influencing how the therapist is applying the ACT model and integrating it into their practice.
Why Therapists choose to use ACT			
	1. Personal Philosophy. 2. Therapists wellbeing. 3. Freedom from struggle. 4. Doing what works. 5. Enhancement of therapeutic skills.	Robert: " *what ACT gives you is the reason why [ ]and the direction to travel in [ ] and what the point in doing it all is*	Reasons for selecting to work with the ACT model.
The purpose of theoretical knowledge			
	1. Professional standing 2. Therapist as teacher. 3. Therapist as expert. 4. What the client needs to know.	Robert: *"the most fantastic bit of education you can give a person [ ] who is acutely grieving, is the permission to feel that way"*	The role of underlying knowledge within the therapy session.

Full thematic charts in appendix J

The Analysis is now presented under its respective superordinate and subordinate themes:

3.4.1. Superordinate Theme One: Facing Grief with ACT.

Grief is usually viewed as a natural process of adjustment to the loss of someone and as a period of adjustment to this loss and the associated sorrow. One therapist describes the process as he sees it:

> *"..as far as I know sorrow works like this, if you have enough, tears come out of your eyes [ ] if you have more cries come out of your throat [ ] if you have more, your whole body shakes [ ] and if you lay down on the bed in that condition, one of two things will happen, after a while, you'll find that it's stopped, or you'll fall asleep and wake up[ ] and find that it's stopped and then you'll get up and have a sandwich. [ ] Because as unbelievable, as unbelievable as it sometimes seems, life actually does go on [ ] and so the real question is, how do you go on carrying this sorrow as gently as you can.."*
>
> (Frank: 230-247).

The transcripts reveal some typical reactions the therapists find themselves presented with during therapy and how they then work with these.

The following table shows which therapists spoke about each subtheme.

Table 2. Facing Grief with ACT: prevalence of sub-themes.

Therapist	**Managing emotional states**	**Dealing with Intrusive thoughts**	**Working with Guilt & Anger**	**The role of Memories**
Robert	**x**	**x**		
Dawn	**x**	**x**	**x**	**x**
Katy	**x**	**x**		
Sam	**x**		**x**	**x**
Frank	**x**	**x**		
Sophie	**x**	**x**	**x**	**x**

X = occurrence of sub- theme.

3.4.1.1. Managing emotional states

As might be expected all the therapists have been faced with strong emotional reactions from their clients (see table 2 above) Sophie talks of clients saying *"I'll never get over this, or I want to die"*(156), and of the intensity of these emotions *"at the beginning of the grieving process, the grief is totally overwhelming and your self is completely [ ] sort of swamped by it"*(244-251).

The therapists all speak about how they address this key issue within therapy. Dawn talks of the importance of making space for the expression of emotions *"you have to make space for the pain"* (106-107). Robert speaks about "*the move away from thinking that er, erm, a healthy state is an unemotional state or a calmer state"*(284- 288), he goes on to explain that the underlying message is not one of avoidance, or making people *feel better* (932-933). There is the sense that experiencing pain and emotions is both acceptable and essential.

The therapists shared some common ways of working with such strong emotions:

a) Acceptance.

Sam agrees with Robert that the aim of therapy is not to make the grief go away *"it's about acceptance of grief as a process and letting it be there"* (552-524), *"it doesn't take the sadness away"* (199-203). She sees this as an advantage to working with the ACT model and goes on to describe how grief becomes more workable, saying it is normalising, helpful and reassuring without actually doing anything reassuring. She talks in greater length about what she observes:

> *"the sadness [ ]stays the same [ ]but somehow it also changes, they still feel sad and they're still grieving and there is still the loss, but somehow there's a different, it's a different feeling, I find, can't describe what I see in what they are telling me [ ] but it's like it's kind of, I feel sad but it's ok.* (Sam; 564-572).

She goes on to talk about how clients seem relieved not to have to control their emotions. Sam talks about how she uses metaphor to aid the clients' understanding of struggling with emotions, citing the ACT quicksand metaphor. The quicksand metaphor is designed to offer clients a new way of viewing and dealing with their emotions, rather than attempting to control, express or change them, it likens our struggle with emotions to the pointless struggle one might attempt in quicksand, the more you struggle the deeper you go and the more you get stuck. If however you were to allow your whole body to get in touch with the quicksand you would not sink and likewise if you were to get in touch with your emotions, which contain valuable information even when painful, you could observe the experience from a place where thoughts cannot harm you and cannot overwhelm you. Sam also uses her own metaphor which she calls the runny nose metaphor; she uses this when

the client expresses concern that they cannot stop crying. She suggests the connection between having a cold when your nose will just not stop running and there is nothing you can do to stop it, you just have to let it run and eventually it will stop of its own accord, in the same way you cannot turn of the tears, you just have to let them come.

Frank describes the opposite of acceptance as avoidance *"because it's painful people tend to go back into the little house where they don't feel anything at all.."*(278-279), he likens this place to depression, this unhelpful approach, he suggests, means you cannot experience any positive emotions either. When talking to his clients about acceptance, Frank likes to use the phrase *giving your permission,* he feels it is important to emphasise this as an active rather than passive process.

b) Mindfulness/present moment awareness.

Again Robert feels strongly that emotional avoidance is unhelpful; he talks of clients being *"sucked into emotional avoidance"* (745-748) and describes the clients' awareness of this as being an important marker that they are moving on. He notices them becoming more aware of what is happening in the present moment. Frank also refers to avoidance, asking his clients *"when you avoid making contact with your sorrow, how's that work? [ ] does it really help?.."*(676-678).

Katy says *"when people are really distressed, being in the moment mindfulness stuff is really helpful.."*(118-119), Dawn also finds it helpful for what she calls *"emotional regulation"*(412) and goes on to say that in her experience clients become less upset about things *"which in the past would have made them go a bit wild"*(520-522).

Sam describes how she focuses a distressed client during a session, *"I might then ask would you be willing to, you know, to stop [ ] right there, just notice what's*

showing up right now for you, where do you feel that in your body, right now.."(603-608). She uses techniques such as breath focus, or body scan to help them practice being in the present moment. Sophie also encourages her clients to fully experience their emotions in the present moment:

> *" if we sit in the present moment and just feel the pain and we do a little bit here [ ]and they might cry, oh God, you know. Where do you feel it? [ ] go into focusing, and they can actually move on.."*(281-286).

3.4.1.2. Dealing with intrusive thoughts

Death and the loss of a loved one tend to cause rumination. The therapists expressed some thoughts surrounding this issue and how they work with it in sessions.

Katy describes what she sees as a kind of rumination about the details of death and the missing and yearning for the deceased, she finds that a lot of people's symptoms are exacerbated by what she calls their *"kind of critical self-talk"* (69). Of course when we are talking about grief, as Robert points out "*the content of the thoughts that are most troubling to people maybe, devastating and catastrophic [ ] and are often completely accurate*", (45) and thoughts that he describes as very difficult, very troubling and very traumatic thoughts *"will intrude [ ] they just will"* (572- 576).

A word used by both Sophie and Frank to describe what they see is '*awfulising',*

> "*people are awfulising about the death of someone [ ] it's not only bad it's worse than it can even be.."* (Frank: 634-637)

The approach used by the therapist can be summed up using Frank's words *"so even true thoughts are nothing more or nothing less than true thoughts..."* (515-516). Robert finds that ACT addresses what he calls a central issue - the troublesome nature of client's thoughts:

> ***"*** *traditional CBT doesn't have a lot of technology for dealing with that [ ] hence the mindfulness bit [ ] where there is emphasis on not challenging thoughts but upon sort of on the acceptance that they are present…"*(45-48).

Dawn talks of using defusion exercises when clients are fused with their unhelpful thoughts (121-122). Katy also finds it useful to separate things out, anxiety about the death as a separate thing from the death itself (233-239). Robert talks about how clients can, by seeing their *self as observer* defuse from their thoughts, later he goes on to offer a metaphor to explain this further:

> *"..so the idea that your mind is like a radio that's broadcasting [ ] you can't turn it off, [ ] You can't choose what channel it's on [ ]You can't turn it to silent, er, and it's just like learning to live with it there in the background.."*
>
> (763- 770).

3.4.1.3. Working with Guilt and Anger

Sam describes clients as feeling either guilty because they are stuck in their grief or guilty for moving on and still finding enjoyment in their lives (188 & 215). Dawn says there is a lot of guilt, which can sometimes be survival guilt or regrets over "*things that they should have said or things they should have done"*(124-134). The therapists talk about how defusion exercises again can be helpful, Dawn says:

"So with the grief and loss clients I will use the diffusion of images the unhelpful thoughts of guilt for instance [ ] so I will do it with the guilt feelings, because they are really not helpful."(285-297).

Sam says she never measures clients' guilt, *"but I think subjectively what they are saying is that they are a lot more compassionate with themselves, they don't view, the tears [ ] as, you know something that's bad."*(552-557). *She* speaks about this acceptance of feelings, recalling a client example *"she said I don't feel guilty anymore, I don't feel bad about myself [ ] I, you know, it's just one of those things [ ] that's happened to me"* (851-856).

Sophie talks about stages of grief and likens anger to self as context. She talks about a particular client who needed to feel free to express her anger (577-579).

3.4.1.4. The Role of Memories

Several of the Therapists describe memories as both precious and troublesome. They distinguish between the two.

Precious memories, they feel do not need any work. Sam says:

"what I've found is that, people, and that every person that I've used ACT with, with bereavement, one of the things they want to do is, they, they want to keep, you know, the person alive in their memory…"(181-184).

Dawn agrees, she does not work with defusion of the fear of the thoughts of the person that died "*because that's precious and that's their memories and their feelings so I won't go there..."*(288-292).

Therapist can use the clients' memories to aid their work; Sophie suggests they think of the deceased together for a moment (553), Sam asks clients to get into contact with what was important to them about that relationship (191-192).

It appears that troublesome memories can be dealt with in a similar way to troublesome thoughts,

> *" ..memories that keep coming up about the moment of when that person die, dying, or the days before, because if they were sick a long time and that's the last memory they have of things being very unwell, so yes I work with the fusion exercises, thoughts come and go and the, the image, the image we try to change the image..."* (Dawn: 126-130).

The therapists have all described positive and relatively successful experiences when using ACT based interventions for common grief reactions expressed by their clients.

3.4.2. Superordinate Theme Two: Factors shaping application

This theme encompasses emergent elements reflecting how the therapists are actually applying and integrating the ACT model into their practice. This theme is the 'how' rather than the 'what' of the previous theme. The following table shows the occurrence of the sub-themes from the therapists' transcripts, and reflects how prominent these topics were.

Table 3. Factors shaping application: Prevalence of sub-themes.

Therapist	Therapists own influence	Knowing something is not living it	Integration of other approaches	Unique nature of each client
Robert	**x**	**x**	**x**	**x**
Dawn	**x**	**x**	**x**	**x**
Katy	**x**	**x**	**x**	**x**
Sam	**x**	**x**	**x**	**x**
Frank	**x**	**x**	**x**	**x**
Sophie	**x**	**x**	**x**	**x**

X= occurrence of sub-theme

3.4.2.1. Therapists own influence

Undoubtedly no two therapists will work in exactly the same way. Evident in the transcripts was the therapists own personal influences shaping the therapy sessions.

When asked about his use of metaphors, Robert describes those he uses as not necessarily originating from ACT, but he feels they make sense in an ACT framework (276-280). He speaks of having a favourite (350-351), which seems to have become so due to its success rate with clients. He has not stuck to use of what he describes as *the classic ones,* pointing out that some may be culturally specific (359-365). He assumes that if he does not fully understand the metaphor, then neither will his client. Robert holds personal strong beliefs about adjustment to one's own or a loved one's death (834-835), which naturally influence his approach *"...It's a transition and a very difficult transition and a thing to be adjusted to and adapted to".*(818-819). Robert describes his way of working with ACT in the following way:

"… you have to work lightly and you carrying that maybe as your model [ ] and you're, you're sort of weaving into that an awful lot of, sympathetic listening..(375-379).

Dawn also talks about her use and choice of metaphors, again she has ones which she *likes* (71-80), she points out that another she uses quite a lot is from a book written by a Brazilian (81-91), like Robert it appears that understanding on a cultural level is significant in therapists connection to and use of particular metaphors. Frank uses his own childhood experience of living in Texas in a metaphor devised to help clients understand the difference between sorrow and depression (253-298), which he sees as qualitatively different. Frank's metaphor involves the weather, something which Sophie also uses with clients when talking about feelings *"feelings are like seasons [ ]and you know, sometimes you've got a high raging summer and everything's really horrible and then it will quietens down…"* (164-167).

Context or therapeutic setting may also influence how the therapists work, Katy talks of working in other areas to bereavement for three days a week, she implies that this influences her existential/humanistic approach (81-85), Robert describes himself as taking a *compromised position* (879-894) adjusting his work to suit the client. Katy talks about her own input when she says *"I kind of adapted them, like I've written hand-outs that are my adaptation of what other people did"* (396-397). Both Dawn and Sam talk of their own input *"it just comes to mind to do something different"* (Dawn: 141), *"things that might just occur to you of the top of your head"*(Sam: 233-236). Sam describes *flexibility* as being key (75-77).

Sophie's own dislike of filling in forms she feels is projected into her work (345-348), she believes people do not want to *"fill in forms on a scale of one to ten",* her own personality is also reflected in her talk about how ACT is taught (806-817).

Her belief in stages of grief is grounded in her own personal experience of grieving (180). Sophie makes her personal beliefs clear when she says *"I truly believe that as human beings we've got these nine intelligences"* (480-485), this can be seen to influence her style of working (231), she says *"I tend to use the body…."*(366-369), implying this may not be the standard way of working.

It is evident that Franks own academic work is a major influence in shaping his practice:

> *"I don't know if you've run across any of my work but when it comes to, err things like willingness, I'll talk about willingness with your feet and willingness with your heart [ ] and willingness with your heart is like, holding something gently, you can hold a feather gently, and it's gentle and you can hold the fruit of a prickly pear cactus gently and it's not gentle.[ ]And so being willing with your heart is holding thoughts and images and sensations, basically thoughts and feelings gently whether they're gentle or not [ ]and with that kind of, with that kind of description then I can ask, are you holding this gently?"* (127-140).

3.4.2.2. Knowing something is not living it

The origins of the word *know* can found in two distinct Latin roots: *gnoscere* (knowing by the senses) and *scire* (knowing by the mind). This distinction is evident in ACT with its move away from knowing this consciously. To this end, ACT is known to promote the use of experiential exercises; the therapists all offer some dialect about this concept within their transcripts.

"I think the whole idea of ACT is the less we talk about it and the more do it, the more we have success" (Frank: 147-148).

Katy uses a comparison with her previous CBT work, expressing that she believes that ACT *"really gets more to the core of things, than standard CBT"* (342), she goes on to elaborate why she thinks this might be:

"the fact that someone did have insight and it still wasn't shifting anything, you know they might be stepping through the motions and it wasn't really shifting anything (344-347).

This suggests that she feels understanding alone is not sufficient to bring about change, and that working with ACT is a profoundly different experience.

Robert's words portray the active nature of the therapy *"what are you going to be talking about, when I use the word values now"* (227-228), he goes on to say the clients begin to notice a change in the way *they* speak and he experiences them within a session (755-757). Frank puts it clearly *"rather than explaining choices I'd ask people to make choices…."* (122-125). He also points out, rather importantly, the need for the client to be active "… *but nothing works if people don't do it"* (Frank: 417), again implying that ACT is about more than knowing, it's about living.

3.4.2.3. Integration of other approaches

It appears that none of the therapists consider themselves to be 'pure' ACT practitioners, when working with bereaved clients they speak about how they incorporate other elements into their work.

The way in which Sophie has been able to integrate ACT into her work seems very important to her, she is very creative and she describes ACT as very "*marryable",* she emphasises her point saying *"I've even mixed it with Jungian stuff*

[ ] and dreams, it's just great" (32-36), perhaps suggesting this might be quite unusual or in some way the idea of such an integration shows how usable ACT is, Sophie seems to be able to connect ACT to many different approaches or theories; shamanic ideas (438), neuroscience, attachment, neuroplasticity, nine intelligences (474-485), she speaks about how she sees a connection to stages of grief:

> *" if you look at it, you've got denial, which in a way could come with defusion, then you've got anger, which could be self as context, what have you got then, depression, well that could be contact with present moment [ ] feeling depressed, [ ] you've got bargaining [ ]so bargaining can be something to do with values and acceptance, then you've got the depression which is feeling the depression [ ]then you've got the acceptance [ ] which is acceptance.*" (177-202).

The other therapists also mention the use of other approaches, and how ways in which they had previously been working are not forgotten but somehow ACT is seen as adding to them. Frank talks of how his REBT work already contained a big component of acceptance (438-439), Sam talks of how MBCT is quite *"ACT consistent"* (53-54).

Both Katy and Dawn discuss how integrating a narrative component is important when working with the bereaved (Dawn: 363-367; Katy: 142-149), they consider this to be important "*in terms of rapport building with bereavement clients"* (Katy: 142-149). The therapeutic relationship is not forgotten by Robert who speaks of *"weaving into that an awful lot of, sympathetic listening..."* (378-379).

Katy and Robert agree that behaviour activation is very useful when integrated into ACT (Robert: 619-622; Katy: 58-63).

Katy and Robert sum up the overall impression derived from the transcripts when they say:

> *"I don't work only with ACT techniques [ ] but that is something I use a lot of"* (Katy: 36-38)
>
> *" you'd probably see more ACT than any other one form of therapeutic method..[ ] and you certainly wouldn't call it pure or strict ACT, cos so many other things are happening that I'd argue kind of need to happen.".*(Robert: 539-544).

3.4.2.4. Unique nature of each client

Most therapists would agree that every client is unique. The transcripts reveal how the therapists in this study are able to tailor the way they work, especially with metaphors to bring about a very individual experience for each client.

> *"I think, erm, because, the, you know you can use practical examples and, and metaphors that relate specifically to the individual experience of the world so, so, I think it's quite easy to cater it to the individual"* (Katy: 41-44).

Dawn also speaks about how she uses metaphors that relate to the client's life experience or line of work (152-154), Sam talks of how she builds metaphors based on the clients' experience (238-242).

This subtheme includes the issue of timing of interventions which again is individual to each client. Sophie says *"Well actually it depends on the person..."*(388), Robert speaks of saying to clients *"I'm just wondering whether now is the moment to do that?* (469).

It is apparent that the therapists recognise the many variances in an individual's experience of grief, with Robert talking about the varying numbers of sessions a client may require (563-568), and Frank differentiating between types of loss:

> *"... you're not going to make a new parent, er, you certainly can have another spouse, or another mate [] you can go on with your life differently if the loss is a mate, than if your loss is a parent"* (216-227).

Katy describes how she uses normalising to help clients see that there are some common things about grieving experiences, yet *"the unique way of doing it is ok"* (73-75) and that she can find something within ACT for everyone (173-179).

3.4.3. Superordinate Theme Three: Why Therapists choose to use ACT

As Psychologists we place great importance on our own philosophical standing and need to feel comfortable with whichever approach we choose. The therapists talk about some of their reasons for selecting to work with the ACT model.

Table 4. Why Therapists choose to use ACT: Prevalence of sub-themes.

Therapist	**Personal Philosophy**	**Therapists well being**	**Freedom from struggle**	**Doing what works**	**Enhancement of therapeutic skills**
Robert	**x**	**x**	**x**	**x**	**x**
Dawn		**x**	**x**	**x**	**x**
Katy	**x**	**x**	**x**	**x**	**x**
Sam	**x**	**x**	**x**	**x**	**x**
Frank	**x**		**x**	**x**	**x**
Sophie	**x**	**x**		**x**	**x**

X = occurrence of sub-theme.

3.4.3.1. Personal philosophy

Personal Philosophy was spoken about by five of the six therapists (see table 4). The matching of one's own assumptions and values with the philosophic stance of a therapeutic model is important. Without this one could assume that any therapist would find it difficult to work within that paradigm, and would indeed not choose to do so. Philosophical position seems important to the therapists interviewed in this study.

Frank goes to great length to explain the importance of his decision to become a Counselling Psychologist:

> *"..I knew that I was not interested in kind of err, people get sick and they have, diagnostic symptoms from their illnesses and that's what we do [ ] counselling psychology didn't have that set of ideas, it had much more the idea that people have difficulties in life .."* (57-62).

Katy also talks about difficulties, saying:

> *" I, like the, the acceptance and difference and difficulties and I guess normalising our humanness is something that I, I think is really fantastic, erm, and I hadn't found a therapy, therapeutic approach that had an expressed that so clearly."* (360-363)

Robert makes it clear that he does not change his therapeutic approach every time something new comes out*, "I have no philosophical excessive attachment to any of them, erm and so I will use the thing that seems most useful"* (846-848).

Sophie also describes ACT as *suiting* her; she has practiced meditation and mindfulness for some time now and she talks of ACT fitting with the idea that is *upmost in her psyche* (49) that we as humans suppress things and struggle to commit to change, with acceptance she believes this is possible.

Sam speaks very openly and frankly about how ACT has changed her standpoint as a therapist, she speaks about having been a CBT practitioner for many years, and holding the view that "*I'm the therapist I'm in control*" (323). It appears that through using mindfulness and attuning to clients feelings, she has also become more aware of her own. She describes a continuum which she believes therapists can be plotted on:

> *"one end of the continuum is like the, the kind of soft, fluffy, bunny, kind of very feely kind of person…..The other end is like, I'm the therapist I'm in control…"* (320-323).

She says *"ACT has really made me think about that..."* and talks of rejecting the extreme of being in charge, describing one of the side effects of this being that she sometimes feels quite tearful. She describes how she *notices the tears* in a way which sounds congruent with what she is asking her clients to do when they get in touch with their own feelings.

3.4.3.2. Therapists' well being

Five of the therapists spoke of the positive effect that working using the ACT approach has had on them personally.

Robert talks about how ACT sets all the suffering into a context that people will find positive, because of this he feels he has more he can *usefully do with a person*, subsequently he goes on to describe his impression of this:

"... it could of course simply be that it makes me feel better about it, I feel less helpless" (526-527)

Dawn talks with a sense of achievement when describes positive feelings for both herself and the client, especially when she is able to relate to the client and make the therapy feel personal to them, *"yes that's a very good feeling and I think I, a very good feeling for them too".* (176- 177).

Katy also talks about a shared experience, saying:

"I think bereavement is one of those times when, you know where you're levelled out, no matter who we are there's this stuff that we have to face and go through, and, then do it in a unique way [ ]but there's something so human about it and erm, accepting that that's going to be hard in one way or another and that we are going to cope or not cope one way or another, I think it's fantastic to be able to say [ ]you know it's ok…" (365-373).

Sam describes a significant change in her attitude to bereavement work since the introduction of ACT; she compares this to how she felt previously as a CBT practitioner:

"I like working with bereaved people now [ ] before, if you'd have asked me, where is your heart-sink patient? [ ] where's the one when you read the referral letter, oh my God [ ]its bereavement [ ]because CBT is symptom reduction [ ] and, what do you do!". (153-166)

Learning and practicing ACT has had a profound effect on Sophie, she says:

"So, in a way that's made me, more whole? And in feeling more whole, I feel I can be more present there for the client." (443-444).

*"More true to myself and able to give more..."(*446)

She sees it as really enhancing herself both personally and professionally, and goes on to talk about how she feels it has integrated her as a person, *"I suppose one of the most important things actually was my own integration [ ] and my own path, with ACT and doing my integrative degree, this last year.."*(448-451).

3.4.3.3. Freedom from struggle

Five of the therapists talk about a struggle to bring about therapeutic change; importantly they have all found that using ACT frees them from this. This is seen as an important advantage of using the therapeutic model:

"I suppose the biggest issue with grief work is, erm, is the move away from trying to fix things.." (Robert: 280-282).

"*whereas before with grief, I think we were always stuck in that same kind of place really [ ]it was always like, we are in a control agenda here [ ] so therefore it was there in the room, whereas there's no control agenda [ ] at all"* (Sam:724-731).

Some of the therapists compare their experiences of ACT to using CBT; Robert also talks of the *letting go* of the control agenda. (633). Sam describes ACT as freeing, explaining that this is because it is not about symptom reduction (176-179), she talks of how she felt *trapped* when working with the CBT model and felt it *" couldn't have been helpful from the clients perspective [ ]because they are trapped with it too"*..(168-172). Dawn who has a psychodynamic background finds it more flexible,

explaining *"It's just more comfortable"* (37-38). Frank has an REBT background and goes into great detail about the struggle with sense making in therapy he concludes by saying:

> *"rather than [ ] just hammering away on true or not, it's not working. [ ] And that I see is, is sort of a major place where ACT [ ] rather than skipping that and pressing harder on, well true or not it's not working.*(553 – 576).

He goes on to say:

> *"Well I think the biggest sort of erm, underlying aspect of ACT is that erm, sense making is something that we infuse into the world, maybe helpfully and maybe not helpfully, so this kind of, kind of underlying notion that somehow it all makes sense [ ]er, that's not in ACT, so you don't have to spend any time spinning wheels with sense making [ ]you can just ride past that to directly contact the pain [ ] of loss and the actual facts of, well what are you going to do now?"*(441-454).

Katy talks about how well she thinks the values aspect of ACT can help with grief:

> *"when people are finding, they're not sure what the point is and they're grappling with existential questions, and their whole meaning making process has been turned upside down, actually going back their deep values that someone has, erm, fits really really well*. (121-124).

This view is also shared by Robert:

> " *what ACT gives you is the reason why [ ]and the direction to travel in [ ] and what the point in doing it all is [ ] so that's the other thing it gives you.*(624- 630).

When talking of using values work Sam makes it sound easy, describing it as feeling more *workable,* she says the clients appear to breathe a sigh of relief.

3.4.3.4. Doing what works

It seems important that therapists would choose an approach which works well in the context that they are working. The therapists in this study all have a range of approaches they could choose to implement when working with grief, but they make their views clear:

> *".....if I didn't think it was any use, I wouldn't be doing it, it's as simple as that"* (Robert: 853 – 856).
>
> *"That's why I started using it, because it works"*(Dawn: 469).

Katy points out that the *key concepts* in ACT of mindfulness and values work are *"really kind of spot on for bereavement"* (132-133). She expresses how useful she finds *it "...I don't know whether it's just that I haven't done it with people where I thought it wouldn't fit or whether it has actually fitted with everyone"* (158-160).

Sam speaks of this recurrent notion of distinguishing between what clients are doing that is not working and what they can do which is more workable (511-514), this is echoed by Frank who talks about the unnecessary work of trying to get people in touch with schema or irrational belief when what is really useful *is "what really works is that what you're doing isn't working, let's try something else…"* (615-621). He describes this approach as being *a lot faster and cleaner* (682-686),

there is the sense that this way of working is profoundly different and brings in the social expectations attached to grieving *"when people talk about bereavement it seems to me they often talk about, erm, a stiff upper lip doesn't really work [ ] let's try something else.."*(783-786).

Sophie does not pick out any single aspect of the ACT model but speaks of the whole hexaflex working (889-890).

Overall working within the ACT model appears to be viewed as successful by the therapists and they value the results they achieve through applying its principles. ACT is viewed as a whole package with the hexaflex bringing the individual elements together into something not restrictive or constraining but workable (Sophie: 634).

3.4.3.5. Enhancement of Therapeutic skills

We are all seeking to continually improve our therapeutic skills, and this seems to be a reason why some of the therapists began using the ACT model.

> *"that's one of the reasons for, you know starting to look at ACT, was to be a better therapist [ ] to be more effective"* (Sam: 384-387).

Frank speaks about a searching to improve his practice:

> *"...that kind of evolutionary approach, you know the world will tell you what works and doesn't, and if you'll just allowed to drop out [ ]er, you know to be victims of extinction [ ]err, things that don't work, err then you'll find things that do.."* (623- 628).

Again the therapists compare ACT favourably to other models, Robert says *"..it gives you a way of talking about the inevitability of the pain and the suffering [ ]and puts it into context sometimes more clearly than some other models"*(512-516), he goes on to say *"my impression is that it gives me more that I can usefully do with a person"*, (525-526). Katy also describes it as giving her more, saying it moves away cognitive challenging and *gets more to the core of things, than standard CBT"* (337-343). Sam believes she is now much *better* at working with bereaved clients than she was with CBT (911-912).

Dawn actually attempts to quantify the improvement in her therapeutic skills, claiming it gives her 20-30% extra skills (550-551), and she feels she can now help clients more and her practice has got better. Frank describes now having *some moves* which help clients view things in a more useful way (507-509).

Sophie finds ACT very inclusive, describing it as *"treating the whole person"* including their spiritual side (492-512), and every part of the body (610-618).

This theme has shown the personal benefits experienced by the therapists, in terms of personal well-being, congruence with their own belief systems, ease of working and professional development. The therapists paint a very positive picture of ACT and Sam's comment that she actually likes working with bereaved clients now shows the impact ACT has had.

3.4.4. Superordinate Theme Four: The purpose of theoretical knowledge

Every therapeutic approach starts with a theory, but what purpose does the underlying knowledge serve within the therapy session? The following four subthemes emerged and are presented below:

Table 5. The purpose of theoretical knowledge: Prevalence of themes.

Therapist	Professional standing	Therapists as Teacher	Therapists as Expert	What the client needs to know
Robert	**x**	**x**	**x**	**x**
Dawn	**x**	**x**	**x**	**x**
Katy	**x**			**x**
Sam	**x**	**x**	**x**	**x**
Frank	**x**	**x**	**x**	**x**
Sophie	**x**	**x**	**x**	**x**

X = occurrence of subtheme.

3.4.4.1. Professional standing

The assertion of professional status requires claiming a level of specialised knowledge and skills. According to Abbott and Wallace (1992), the process of professionalization involves a power struggle to be recognised as an expert within a set of social boundaries. This aside, the power that knowledge bestows, is put aside in the interest of helping others and is the framework of ethical guidelines. As an unexpected emergent topic when talking about ACT and bereavement, the therapists in this study all felt the need to portray their level of professionalism.

Dawn spoke of being a trained Psychoanalyst but finding once she moved to Australia she needed to retrain in accordance with the social expectations of that country, (32-34). Robert described how his journey to understand ACT took some perseverance (68-77), he says *"I think this like any therapeutic approach is, is hard to learn to do well"* (443-444). It seems important to him that he persevered with his

quest for understanding once he became interested; he even travelled to the USA to do training (68-77).

Katy and Sam talk of the importance of the input of others for furthering knowledge and validation as a professional, Katy talks of the value of the ACT online discussion group (410- 414), Sam talks of the importance of seeking clinical supervision for her work (23-24), and being hard on herself, continually thinking of ways that she can do better.

Frank values academic input and sees this as an indication of ability, he describes being disappointed that he never got the opportunity to return to an academic setting (15-30). Franks' interview supported this as he often referred to theories, theorists or academic explanations.

3.4.4.2. Therapist as teacher

Once the knowledge of theory has been understood it emerged that most of the therapists referred to ways in which they passed this knowledge onto the client.

> *"the most fantastic bit of education you can give a person [ ]*
>
> *who is acutely grieving, is the permission to feel that way"*
>
> (Robert: 598- 600).

Most of the therapists talk about taking a leading role. Dawn says she *"...can teach the client to use the expansion and [ ] even the diffusion techniques..."* (464-465).

Dawn speaks of explaining self as context to clients, "….*it takes some work to get that concept across [ ] sometimes, and it has nothing to do with the person being educated or not..."*(244-249), she feels it is more to do with cognitive style.

Sophie sees counselling as unlearning ways that aren't helpful for us, and she takes a flexible approach to teaching, she looks for how the client tends to learn,

whether that be by listening, reading, writing or drawing (422-423). She talks of the lasting importance of learning something new *"I think if we've learned something in a different way, we can translate it [ ] for the future…"* (780-783). Dawn agrees that helping clients to view things in a new way is a skill they can apply to new problems in the future (538-544).

Although the therapists speak of how they *teach* the client different aspects of the model, they don't see it as teaching in the normal sense, Frank says:

> *"sometimes people know what's likely to work and mainly what they're looking for is encouragement, sometimes they err, don't know what would help and you try to help them get a hold of what would actually help"*. (414-416).

Dawn talks of coming up with an example to help them (171). Robert differentiates his teaching from that in an academic setting *"I wouldn't see it as a particular requirement of duty to, for the person to go away to be able to answer exam questions on self as context".* (176-178). Frank agrees it's not teaching skills in the normal sense which are required:

> "*You may not be a great teacher, you may not be a great err explainer [ ]of what it is you're doing, but people don't really come to us in order to be ex, to explain how to have [ ] a more fulfilling life. [ ] They come to have it!* (736-743).

3.4.4.3. Therapist as expert

With all their experience and theoretical knowledge, do the therapists see themselves as experts in the subject? Their rhetoric suggests, perhaps rightly so, some evidence to support this.

Frank is particularly confident in his abilities *"...I never have any trouble getting them to see"* (523-524), he talks about having his own *formula* for serenity in action (321-322), he suggests an air of superiority, saying *"there's lots of ways to go wrong, but because I can articulate that one [ ] then I can be on the lookout for it..."* (380-382).

Robert too is confident in his own ability *"... but some of it is, stuff that we know that he's not in a position to know..."* (390-392). He sees his presence as essential when clients work at getting in touch with their emotions*, "...the first time has to be with you in the room..."* (921-922). When asked about how he explains the concepts of ACT to clients he says:

> *"...mindfulness, present moment awareness, not an issue really [ ]but I guess that's partly because I've been doing mindfulness, straight mindfulness for years..*(198-202).

He goes on to talk about how he incorporates problem solving and advice giving into his work (370-384). Robert has strong opinions on ACT terminology (218-221) and how it should be used.

Sophie talks about how her knowledge of stages of grief and metaphors she knows can help, she names things, gives them shape, quantifies and qualifies them (210-217). Dawn and Robert suggest the expertise also relates to knowing *when* to implement things. Dawn speaks of introducing the commitment part of ACT, "*...it's not that it's difficult it's just that you have to pick the right time to work with that one*" (213-214). Robert says *"I would definitely lead from the bits that where most relevant at that moment",* (167-169).

Sam however, talks about her struggle with seeing herself as an expert *"I'm kind of rejecting this, like, I'm in charge, I'm the expert, you know [ ] I know the*

answers" (331-333), she gives the sense of a more collaborative approach, yet still she speaks of her role as working out what the client may be doing (526-527) and she has confidence in her abilities when using ACT *" ... I haven't met the person that's bereaved that, that I can't do anything with"* (661-662).

3.4.4.4. What the client needs to know

It has emerged from the transcripts that the acquired knowledge of the therapists sets them up as experts in their field, but how much of this theoretical knowledge actually needs to be passed on to the client. It appears that the therapists see little value in explaining the theory behind the ideas.

Dawn talks about making it *"as simple possible so I don't really give too much, err, err theory for them"* (53-54), she gives it when and where needed:

> *"if I'm working, talking about Acceptance the competence of, then I can give them something on that, also when I work on the commitment part I can give them something on more on that, so I try to explain the model the simplest way I can.."* (57-60).

She points out that clients vary in how much they want to know (63-64). This idea of keeping it simple is also evident in Sam's work *"you don't need to use, particular words or language [ ]to get the ideas across"*(44-46), she focuses more on explaining the rationale for doing something in the context of their distress, (51-55). Sophie too says the wording doesn't matter *"... I don't always explain it [ ] as ACT..."(*68-70) she goes on to explain in more detail:

> *"I don't call it that [ ] I make a star [ ] and I talk about being*

in the moment, the values yes, talk about that, committed action I might not necessarily say committed action, the self as context I wouldn't say that, cos they'd say well what are you talking about [ ] I would put erm acceptance of oneself in the world and how we react with it, or interact with it [ ] defusion I wouldn't necessarily call it defusion, I would call it erm, diluting negative thoughts [ ] instead of diluting negative thoughts, if you see what I mean, and acceptance, well acceptance, yes I do bring that in". (79-94).

Robert highlights the fact that any way of explaining or use of terminology needs to be culturally relevant (210-215), he too chooses his language carefully, explaining that he uses the hexaflex model but *softens* the language (249-256), suggesting academic terminology is not important. Frank agrees when talking about the theoretical term of psychological flexibility:

"You know if I say to them, you know the main goal is to become more psychologically flexible, they might say, well what for [ ] but then if I say in order to live a more fulfilling life then they're, they're definitely up for that.."(494- 498).

Sam compares using ACT to using CBT, suggesting ACT is more difficult to explain (62), but she goes on to point out that although CBT is easier for the therapist to explain*, "probably people didn't get it!"* (106-114), proposing that they were just socialised to the model. She explains what she does do:

"I want them to get to the idea that this might be very different to what they have been doing before or sometimes it might seem a bit counterintuitive, the opposite to [ ]what they feel

drawn to. And that's ok, and we can talk about that [ ] are they willing to, to have a go at that, given that it might sometimes feel, the opposite to what their [ ] instinct tells them to do [ ] so I would go, I'm going with that kind of description". (125-136).

She has experienced it as unhelpful to try to explain the model, saying *"otherwise I'm finding that I'm going to get drawn into this great long dialogue [ ] where people kind of glaze over.."*(141-144).

3.4.5. Summary

The therapists' accounts of using ACT in their practice found them to be using key components of the model in their work with grieving clients. They reported positive and what they described as successful experiences of using the approach. The development of themes found some commonality in grief reactions with which their clients were presenting and they were then able to address. The themes also identified influencing factors which shaped how the therapists were applying the model and their reasons for choosing to work in this way, with subthemes identifying what they saw as intrapersonal benefits to using the approach. Knowledge emerged as an important area for discussion by the therapists and this is also reflected in their themes.

3.5. Findings from client study

Reading and subsequent analysis of the transcripts produced three Superordinate themes (see confidential attachment for annotated transcripts); these are presented under their descriptive labels along with emergent sub-themes in table 6, and are then discussed.

Appendix K provides a full thematic chart, with quotes from the clients.

Table 6. Superordinate themes and Constituent sub-themes (Clients).

Superordinate Themes	Sub – ordinate Themes	Example illustrative quote	Summary of theme
The presence of undesirable thoughts & feelings.			
	1. Envy. 2. Guilt. 3. Anger. 4. Intense emotional pain. 5. Intrusive thoughts.	Beryl; *"…actually I wanted to pierce my heart with a knife"* *"anything just to let some of the grief out.."*	This theme gives a sense of the clients need to find a way of coping with their grief.
Client perceptions of the therapeutic process:			
The role of the therapist. **Change brought about through therapy.**	1. Therapist as listener. 2. The relationship as imperfect. 3. Trust in the therapeutic relationship. 4. The emergence of new ways of being. 5. Learning to embrace the truth.	Beryl: *"There's no right and no wrong way…what I'm feeling is what I'm feeling"*	The client experience of therapy, the therapeutic relationship and the process of change
Adapting to life without the deceased			
	1. Implications for self. 2. The expectations of others. 3. Finding new purpose & place in society. 4. Continuing influence of the deceased. 5. Spiritual proximity to the deceased.	Beryl: *"and so you do actually have to find a new you and I'll never be that person I was with Ryan"*	The clients understanding of their present situation and future.
Full thematic charts in appendix K			

The Analysis is now presented under its respective Superordinate and sub-themes:

3.5.1. Superordinate Theme One: The presence of undesirable thoughts & feelings.

The clients both spoke about how grief was affecting them and the presence of strong, undesirable thoughts and feelings which had led them to seek therapeutic help.

3.5.1.1. Envy

Envy is usually derived from making social comparisons, the standards we use to see how well off we are, become not the intrinsic worth of our own well-being, but how it compares with that of others. It is defined as a form of distress felt by the subject at the thought that he or she does not possess something which someone else does (Farrell, 1980). Common language often conflates envy and jealousy, with Beryl herself using the word *jealous* when it appears she actually was experiencing *envy*. Although only Beryl spoke about her envy, it was a prominent feature of her discourse:

> *"My sister's husband is still alive my ex-husband, first husband... [ ] and it doesn't seem fair [ ] And my dad lived till he was ninety-three [ ]and he died a year after Ryan but I was furious that he was still alive when Ryan was gone"* (589-598).

There is a sense that Beryl sees this as unjust, she gives examples of others who she may be suggesting don't deserve to be alive or to have lived that long. She places high value on Ryan as a good man, and her first husband as not, therefore she feels Ryan deserved to live longer. There is the sense that Beryl holds the belief that there is a way 'things should be', the eldest die first and the good live longer.

Beryl spoke about how difficult she had found it, and how strong her feelings had been, *"I used to feel angry about erm seeing couples down a street [ ] I used to want to smack them [ ]or have to go away from them"*(616-620), she uses the past tense here suggesting a degree of cognitive change which she backs up by saying that now:

> *"I can feel jealous, I can feel sad [ ] I can wish that it was Ryan and I [ ] but I've lost the anger about other couples down the street..."* (622-626).

3.5.1.2. Guilt

Guilt is an emotional warning sign that most people learn through normal childhood social development. Its purpose is to let us know when we've done something wrong, however when guilt is inappropriately attributed it can be self-destructive and harmful (Harder, 1995; O'Connor, Berry & Weiss, 1999). Both Beryl and Jim speak about feelings of guilt both in terms of regrets and their current needs. Beryl's guilt seems focused around the idea that she might forget Ryan:

> "*I still feel as if erm I feel as if except for short moments.[ ]..I've pushed him away"* (213-215).
>
> *"I walked for hours and hours but I felt as if as if what? As if my, it wasn't real... [ ]..as if in fact I'd never known Ryan, as if I'd never been married to him"* (167-169).

Beryl has certain expectations about what she is capable of; these expectations seem to have derived from her comparing herself to others. She explains how therapy is helping her with this:

> *" ...it's helping me mmm to know that there's no one way and that, you know friends of mine who talk to their husbands don't necessarily mean that I have to be able to talk to Ryan.. [ ].err, each one of us copes in their own way."* (248-251).

Jim too talks about his guilt:

> *"... [I] loved going out and talking to her[ ]but I found that when I was leaving there I felt as if I was coming home here[ ] but I was leaving her behind [ ]and that was affecting me[ ]er to think that, that I could come here, but she had to stay there"* (676-684).

Jim's guilt seems centred around the idea of leaving his wife, it seemed important to him that he be there to care for her, he speaks with much regret about their last years together:

> *"unfortunately she spent, erm two and a half years in a nursing home up here before she passed away because I could not look after her at home."* (151-152).

Jim visited his wife every day and again was upset when circumstances meant he could not visit her due to his illness.

3.5.1.3. Anger

Anger is said to comprise of three elements, cognitive (appraisals), somatic-affective (tension and agitations) and behavioral (withdrawal and antagonism), and whilst viewed as a primary, natural, and mature emotion with the purpose of aiding

survival, when uncontrolled it can have detrimental effect on a person's personal and social well-being (Novaco, 1986).

Beryl speaks a lot about experiencing very strong anger, her anger it seems is directed at anyone and anything:

> *"I went to a memorial erm service and the palliative care doctors that I knew there, I just sat and wept through the whole thing and I was furious and angry with the people at the service and angry with what had happened to my husband.."* (47-49).

When asked if she had any idea what the anger was about, Beryl replied:

> *"Well some of it's about erm him dying on me, [ ] me feeling that perhaps he didn't fight as hard as he might of.."*
> (585-587).

Beryl described how she is working in therapy to cope with these feelings:

> *"well I'm just taking, small steps..[ ].to erm admit my, allow my anger to come out. [ ] It's very hard for me, I mean I've spent years and years squashing those things down.,"*
> (604-608).

3.5.1.4. Intense emotional pain

Despite having been through past significant bereavements, Jim talks of his 'hurting' as being a major part in his decision to seek therapy in this instance:

> *"I decided to have, that I had to have some sort've counselling [ ]because the way I was [ ] er it was hurting [ ] between the stress and the grief "* (784-790).

He talks about having additional stresses in his life which may have made the grieving process more difficult for him. Again, Beryl talks about this 'hurt', her words reflect the intensity of the pain she felt:

> *"I, well actually I wanted to pierce my heart with a [ ] erm you know a knife...."* (77-79).
>
> "*anything, just to let some of the grief out [ ] or to have something else to hurt me [ ]that may take away my emotional [ ]hurt."*(81-87).

The intensity of Beryl's experience can be seen when she goes on to say that she is able to identify with the American Indian women who used to cut a finger off (66-67), suggesting she feels like she has lost part of herself. There is a sense of the uncontrollable power of the emotional response she experienced, using words like "suddenly" to describe the onset of emotions (419), "horrible noises"(426-427) to describe the demonstration, and "swirled up"(1057) to describe the turmoil of previously suppressed emotions.

Jim describes having "gone through" therapy as a "major relief" to him (1026). Giving the impression that it has alleviated some of his pain.

3.5.1.5. Intrusive thoughts

Both of the clients talk of their thoughts being initially overwhelming and somewhat out of their control, yet now they are able to accept them as just thoughts.

Jim describes his thoughts as the most troubling aspect of his grieving; this constant rumination was something he felt unable to control:

> *"Well it affected me er by er I would sort've sit down here in the house and er I would just sort've I couldn't get her out of*

me mind..[ ]... erm it was she was always there just going through different things she do in the day …" (585-588).

He talks about how he feels therapy has changed this, *"It's still there that little thought that's still in my mind [ ] but it's not sort've taken over my mind..."* (746-748). Now Jim seems to have gained some mastery over his thoughts and be able to regulate them.

Jim has spoken about his guilt at leaving his wife behind in the cemetery, he describes how his therapist has helped him to focus on positive things and in his words *"just try and sort of put the other one aside [bad thought]to a different part of your mind.."* (697-699), and now he finds *".. I'm able to do that, erm I don't erm leaving her behind I know I'm leaving her there but it's not troubling me…".*(739-740).

Beryl has also experienced positive changes in the way she deals with the very strong impulses she experiences, although she describes them as feelings, I suspect that these are associated with intrusive thoughts:

"if I'm feeling it if I want to cut myself.. [ ]..it can be a very, erm very powerful feeling.[ ]and I just sit there and think you know that's alright you don't really, this is a feeling you've got but you don't really want to act on it and er take some breaths and..[ ]..err, just go with the feelings and let them…[ ]..let them reduce." (468-477).

Putting this simply she says*, "Well I try and just let let the feelings come and not take action on them..."* (466).

3.5.2. Superordinate Theme Two: Client perceptions of the therapeutic process.

This theme encompasses two areas:

a) The role of the therapist.

b) Change brought about through therapy.

It has been divided into aspect of the relationship which the clients have spoken about and the change in themselves they attribute to engaging in therapy.

3.5.2.1. The role of the therapist.

The basis of any good therapy is accepted as being a good relationship, this is borne out by the interviewees, Jim pays particular attention to therapist as listener and Beryl describes some disagreements with her therapist, but the strength of their relationship allows her to work through these issues.

3.5.2.1.1. Therapist as listener.

The therapist as a listener was a recurrent message Jim portrayed throughout the interview, suggesting the high value he put on this requirement.

> *"I can talk to her er you know, as a person that will listen"* (972-973).

But this is more than just listening, it's about Jim feeling he can *open up* (918), *get things off his chest* (1175), and be heard in a non-judgemental way. He says:

> *"doesn't matter what I say [ ] doesn't matter what it's about she will listen to me"* (909).

He talks about how much listening has *helped* him:

> *"I found that talking it over with ****** is what's helped you know"* (752).

"....I think just letting me talk [ ] er has been a major help" (1173-1175).

3.5.2.1.2. The relationship as imperfect.

Both participants speak of the therapeutic relationship as experiencing some problems, yet there is the sense that it is strong enough to cope with these. In reality no therapist is perfect, and no therapy provided perfectly, even therapists highly attuned to their inner worlds can make mistakes. Good therapy is said to be "the sum of all the experiences, internal and external, occurring as a result of the imperfect psychotherapy process". In fact alliance ruptures are said to be common, occurring in 11 -38% of sessions (Safran & Muran, 2000b).

Jim's problem centres around two issues, firstly changing therapist and getting used to a new one *"when I started to see her and er erm when this other lady left you know she was very good as well [ ] and I just sort've thought uhh I wonder how I'm gonna go you know"*(829-832), and secondly on a cognitive level. Jim seems to have initially had trouble understanding his new therapist, he says:

"I don't have a problem with er with er you know like the way she talks and that [ ] Er there's just an odd couple of times where I'm just not quite sure what she says [ ] But I pick it up you know er and I've really you know like erm I don't really have any major problem with that..." (1252-1257).

He does not make this clear whether this is when she explains concepts to him, or whether it is something to do with the way she speaks. But he does mention earlier that when he is struggling with ideas, his therapist may use written material to help his understanding (525 & 533).

Whilst Jim is fairly relaxed about the challenges in his therapeutic relationship, Beryl portrays a more intense experience:

> *"I could've smacked her for saying that. (laughs) Erm and that's my three year old, I talk about my three year old who wants to smack people [ ] and spit and things like that and now I realise that's when my angers all tied up."*(661-664).

It is noticeable however, that Beryl has come to and understanding about what this means and where this comes from, so it maybe that the ruptures served as therapeutic tools to enhance progress. Again Beryl notices a change in the way she is dealing with these misunderstandings; she is able to frame the experience as something positive:

> *"where last week I felt very irritable with something she'd said, and when I got home I realised and I wrote to her and then when she sat down today I said well let's get straight into it[ ].so that was very unusual for me to have a go at her [ ] and that's a little step along the way."* (635-641).

3.5.2.1.3. Trust in the Therapeutic relationship.

The trust talked about by Jim and Beryl seems to encapsulate an element of belief in their therapists' professional opinion or ability (Beryl: 1049- 1053) and a feeling of personal safety.

"To actually be able to trust that I can [ ] let go of these things in there [ ] erm even if I don't feel that I can, else erm elsewhere..." (Beryl: 444-448).

Jim talks about his need for trust *"I think of it is, you have these problems and you're gonna get somebody that's in your mind"* (896-897) he describes how he feels:

"I sort've put my trust in her you know [ ] I I don't er really that's just how I feel you know" (1169-1171).

"I do put a lot of trust in [therapist]" (1246).

3.5.2.2. Change brought about by therapy

3.5.2.2.1. The emergence/development of new ways of being.

The analysis finds evidence of change occurring within the clients themselves as part of a positive growth. Beryl's transcript reveals the experiential nature of her therapeutic sessions and the contribution this has made to her wellbeing. Whereas for Jim '*therapist as listener'* was a more dominant theme, Beryl's dialogue focuses more on ways in which she is *learning* and *practicing* new ways of being. She illustrates this when she says:

"*Well we go through some exercises, erm today I actually cried in my counselling [ ]a little bit, er but erm it's, it's still a struggle…recently I started to cry"* (Beryl: 359-363).

She describes how this is not always easy and is something that at first seems absurd:

"I was wondering around in a daze [ ] standing beside the harbour, gazing over there it looked like another

world [ ] where we used to live [ ] so, rather than do that, you know just take stock [ ] and breathe and [ ] It's hard [ ] 'cause you want to say this is ridiculous [ ] It's stupid I can't do this." (262-276).

Beryl also talks about practicing *urge surfing* something she has learned to do to cope with her urges to self-harm or eat. (457).

Jim too describes a new more relaxed state which has helped him cope with the stresses he was experiencing:

"I'm finding that [therapist] has got me to the stage where the stress has gone [ ] when if anything happens in the family it used to worry me [ ] really stress me out and now if something happened I just have the attitude as well, [therapist] explained it to me that you know like they've caused the problem [ ] they should be able to work it out themselves." (494-501).

Both Beryl and Jim recount a change in the way they relate to others, and an acceptance that it is ok to have needs of their own.

"I'm learning to realise that I can't be everything to everybody... [ ] and sometimes that I have to say no."
(Beryl: 921-923).

"...I must have my quiet time [ ] er I have to have a little bit of time away by myself you know [ ] in my own room or [ ]or out, out the back somewhere out there for a while." (Jim: 1048-1054).

3.5.2.2.2. Learning to embrace the truth.

This theme encompasses the display of acceptance evident in the clients' speech. Through their words, their tone of voice and their injection of humour, they portray an acceptance of reality that is as it is, both good and bad. There is the sense that their love for their spouse is real and true, not based on some idealised version of the person.

> *"He considered Sophie his own child [ ] and we just had a blissful marriage. I mean we had the usual thing [] which do generally happen you know, when you first get together.[]He voted one way and I voted another,. (laughs) He was so furious with me saying "you cancelled my vote"[ ]"you cancelled my vote" I said "maybe you cancelled mine!" You know that sort've thing [ ] had a great sense of humour."* (Beryl: 117-129).
>
> *"....in those years she was a villain a real villain..."* (Jim: 316-317).
>
> *"I think it's like all families [ ] argue and [ ] you know, there's no perfect family."* (Jim: 189-193).

Both clients talk about how they are accepting the reality and normality of their grief:

> *"There's no right and no wrong way [ ] ...and what 'm feeling is, what I'm feeling."* (Beryl: 992-994).
>
> *"the only thing at the moment is still that grief there of course [ ] you know [ ]erm that's still there but er eventually that will go"* (Jim: 571-575).

3.5.3. Superordinate Theme Three: Adapting to life without the deceased.

This theme captures the essence of the psychosocial adjustment which is required after bereavement. Psychosocial transitions are commonly defined as events that require people to undertake a major revision of their assumptions about the world; have permanent implications and occur over a relatively short period of time (Parkes, 1971). Parkes (1988) points out that the death of a spouse invalidates assumptions "from the moment of rising to going to sleep in an empty bed". It challenges automatic habits (setting the table for two) and thoughts (I must ask my husband about that) these need to be corrected if the survivor is to live as a widow/widower.

3.5.3.1. Implications for self.

The degree by which an individual is able to adjust their self-identity following bereavement has been linked to recovery (Parkes & Weisss, 1983). In ACT terms fusion to self as content is equivalent to the content of thoughts, emotions, memories and sensations (Flaxman, Blackledge & Bond, 2011), as defining who we actually are, and as such is seen as troublesome. Beryl has no doubts that the loss of her husband has meant an on-going struggle to find herself again, she says "I think I'm still trying to find myself". She describes the need to find a "*new me"* and becoming annoyed when she was told she was still the same person. The strength of her feelings can be seen when she recalls her response, saying that she was screaming *"I'm not because I was half of a couple".*

Beryl's progress can be seen and a sense of self compassion and acceptance felt when she later says:

"And so you do actually have to find a new you and I'll never be that person I was with Ryan" (801).

The closeness of the relationship Beryl had with her husband is portrayed when she says *"we didn't have a circle of friends, we were very self-contained"* (134). Jim had been married for 52 years, and although he does not talk of needing to find a new *self*, he describes his need to keep *sameness* despite his realisation that she is gone.

"grieving is very hard particularly when you've been together fifty-two years ...[ ] mmm it's affected me where I I still think of her everyday [ ]I have a photograph of her erm that I take up to bed every night [ ]Er it goes into the bed with me [ ] every night, I talk to her when I get into bed every night [ ]I talk to her when I wake up in the morning.[ ]Er you know and then I bring the photo down here put it on the table and you know so she she's sort've here" (633-647).

3.5.3.2. The expectations of others.

Both of the clients in this study have been affected by the expectations of others, whether this be socially constructed ideas about how they should behave, or opinions on how and for what length of time they should grieve. Beryl has particularly struggled with showing her emotions, and talks of how her upbringing has shaped her as a person:

"Brought up not to cry.[ ] Brought up not to be angry [ ] Brought up not to say boo..." (342-346).

She talks of making a special effort to attend the memorial service early to be alone, but when other people arrived she felt uncomfortable, this was a private thing, she didn't want to share it, she felt like she wanted to cry more but she couldn't.

Jim has experienced some negative responses when he has told people he is having therapy,

> *"as soon as you mention to somebody that you're having counselling they say uhh God you're gone in the head you know [ ] to a psychologist."* (992-993).

He appears to find this a little strange as he points out that the media are often talking about people having counselling, he sees it as something quite normal (1017-1022). Beryl has been annoyed by the opinions of others who say *"..get over it you forget about them, [ ] that's gone."* She goes on to say how she finds it comforting when her therapist says, "*I don't have to get over Ryan [ ]I don't have to get over it, let go."* (198-202). It seems important to Beryl that others understand this too, she seemed pleased to tell me that a friend whose husband had died at the same time had apologised to her "*she said you know I've been very unfair to you and erm haven't understood, I've been impatient.."* (229-230). It appears even others who are experiencing their own bereavement find it difficult to recognise the individual nature of grieving.

3.5.3.3. Finding new purpose & place in society.

As well as finding a new sense of self, the clients talked about needing to find new purpose, a reason for living. Beryl expresses this strongly:

> *"I wanted to cut myself, throw myself under a bus..[ ] which I almost did, erm I could see no point to life"* (60-62).

She metaphorically talks of trying to find *"my place, my own place"* (805), implying this will not be the same place she shared with Ryan, but she also physically moves house to try and find her new place, getting rid of everything from her past. This approach was not successful for her, she realises she was *running* from her grief. Beryl's actions are an example of avoidance tactics, which she now recognises were unhelpful to her. As an alternative to avoidance of her thoughts, feelings and memories, Beryl has learned 'acceptance' which involves abandoning dysfunctional behaviours which served only to provide short-term comfort.

Beryl goes on to talk about all the activities she is getting involved in, but emphasising that she needs to find something that is meaningful and has meaning for other people (836).

3.5.3.4. Continuing influence of the deceased.

The deceased appears to play a big part in the clients' decision making processes, they still think what their spouse might have said or done. Beryl says *"he does play a part like I went and had my haircut today..."* (847-848) she laughs as she recalls what his comments would have been. She enjoys telling her family stories about what he would say, she recalls saying to her grandson *"oh pa would've done this…" or "pa would've done that…"* (864-865).

Jim seems a little annoyed when he talks about what he has noticed about his daughters

> *"…it's funny that since she's passed away there's just those couple little things that you notice er with our girls that there a little bit lackadaisical on now, that they weren't when she was here"* (348-350).

These values shared by Jim and his wife are still important, and Jim doesn't like to think that they are forgetting this. Jim's wife was a big family person and the family are keen to carry on her traditional family values and spend Christmas together (1035), although on one level Jim jokes about going on holiday instead, he still feels he must carry on as he wife would have wanted.

3.5.3.5. Spiritual proximity to the deceased.

Jim has strong beliefs that his wife is still nearby *"sort of just keeping an eye on you, you know."* (245). Although he questions whether I believe, he has no doubt himself, saying:

> *".. I don't know whether you believe or not but there are things that happen in this home, I tell you, I'm I'm pretty sure she's around"*(229-230).
>
> *"I've been told that you know like that er when things like that happened er they are just letting you know that they're there…"* (242-243).

Jim implies that as Margaret kept an eye on the family when she was alive, so she continues to do now, this appears to be comforting to him. He also finds comfort believing she is with other family members now (1121-1127).

3.5.4 Summary

As with the analysis of the therapists' interview, the clients' interviews also highlighted the specific grief reactions they were experiencing and which had led them to seek help, these were formed into relevant themes. The clients were found to talk about their therapy in two specific areas: the therapists' characteristics and their

role as seen by the clients, and the change they encountered through attending therapy. The clients also reported on their struggles and achievements throughout their process of adjustment, the theme *Adaptive to life without the deceased* encapsulates these.

3.6 Discussion

This study has presented a detailed exploration of six therapists' and two clients' first hand experiences of using an Acceptance and Commitment Therapy approach to grief work. Although limited to two participants in the client group, it offers a valuable insight into the lived experiences of both parties in the therapeutic dyad.

Questions posed to the therapists focused broadly on four areas; their background, how they apply ACT, what they find it is particularly suited to and their views on client change and outcome. Questions posed to the clients focused on the experience of therapy and therapist, their understanding of ACT, their relationship to the deceased, how grief had affected them, what they have found most useful, and how they view the future now. It can be noted that the focus of the therapists' speech is centred on the approach itself, whilst the clients demonstrate little knowledge about ACT itself but can be seen to talk about the concepts indirectly through experience. Yet when examined together through the process of triangulation there is considerable similarity in emergent themes. Discussion of the therapists' themes will follow, client themes will be explored in relation to this;

3.6.1 Facing grief with ACT

The most prominent feature arising from the interviews with both the therapists and clients is the strength of the grief response, conveying a picture of the intensity of the felt emotions. Both client participants in this study had been bereaved by loss of their spouse, it was therefore not unexpected that their distress levels were high; this would support Holmes & Rahe's (1967) findings which rank death of a spouse as the life-event needing the greatest amount of social readjustment.

The therapists were found to be utilising key ACT concepts when working with grief responses in their clients. As hypothesised, the management of emotional states was being achieved by the use of acceptance, mindfulness and present moment awareness. In line with the approach, therapists encouraged their clients to make contact with the pain of loss as opposed to engaging in avoidance tactics (Hayes, Strosahl & Wilson, 1999). In support of this, the clients were found to talk of needing to *let the grief out* and actively *do something about it*. This suggests it is not something that can be supressed and ignored. There is a real sense of acceptance of the unchangeable event of bereavement in the client theme '*learning to embrace the truth'*. The clients talk about how they are embracing this new perspective as part of the theme *'The emergence of new ways of being'*. It appears this is not easy to do initially, one client (Beryl) describes how she wants to say 'it's ridiculous' but she takes some deep breaths and 'takes stock' of what is around her, the other (Jim) talked about initially not fully understanding, but now he says that he can just sit and relax without any problem. Whilst it is thought that most people have the capacity to practice mindfulness, individuals differ in their inclination to be aware and to sustain attention to the present moment (Brown & Ryan, 2003) and the therapists too

recognise that some practice and an element of willingness to try something different is necessary. One therapist (Sam) describes the model as sometimes seeming 'counterintuitive', saying that naturally we tend to want to avoid rather than experience pain. Hayes, Strosahl & Wilson (1999) argue that human behaviour is controlled by immediate contingencies and the short term benefits of avoidance can be quite powerful even when the long term effects of such behaviour are detrimental. In ACT terms this action is viewed as a behavioural trap, and as can be seen in this study, the therapists attempt to undermine this by encouraging acceptance, and identifying the consequences of such actions.

A critical point of working with bereavement is that troubling thoughts are, as one of the therapists pointed out, "*often completely accurate".* This study found that therapists use defusion techniques to help clients come to the realisation that 'thoughts are nothing more than thoughts', and by adopting this approach there is no need to challenge or dispute thoughts, or test out their accordance with reality, thus allowing for an alternative appraisal of life events. The present study supports the ACT models use of defusion techniques as a way of deliteralizing language representations (Hayes, Strosahl & Wilson, 1999), when it finds that that the therapists noted that clients symptoms can be exacerbated by rumination about the details of the death and that this can be processed by separating details about the death itself from the thoughts associated with the anxiety of the death. The client analysis adds to the strength of this argument when they report gaining mastery and regulation over their thoughts which were initially overwhelming and out of control.

The stage model of grief (Kubler-Ross, 1969), proposes 'Anger' as the second stage of a five stage progression through grief. This study would agree that anger is present in the grieving process and has been identified as such, by both

therapists and clients. However there is no suggestion that it occurred at a particular stage of the clients' grief. In fact this study identified several other emotions as being present and troublesome. Both therapists and clients spoke about guilt being present and one of the clients (Beryl) was particularly troubled by envy.

Memories also emerged as an important aspect of grief. This study found that therapists made an important distinction between precious and troublesome memories. Although not a theme in its own right for the clients, there is evidence of the importance of memories. One of the clients (Beryl) described her guilt as being derived from the fact she feared forgetting her husband. Both the clients recalled memories which seemed very significant to them and importantly, that they wanted to continue to share. The client interviews provided two sub-themes relevant to this area; *Continuing influence of the deceased* and *Spiritual proximity to the deceased*. In these sub-themes they speak of their continuing bonds with the deceased. This is not an unexpected phenomenon, Valentine (2008) interviewed bereaved people between the ages of 19 and 58 and found their narratives included reference to them receiving practical, reliable and moral guidance from the deceased. Continuing bonds are now seen as valuable for the bereaved (e.g. Klass, Silverman & Nickman, 1996).

3.6.2. Factors shaping application

This paper aimed to explore how ACT is being applied to bereavement therapy by collecting data on how this was occurring within therapeutic sessions. ACT is fundamentally a process driven approach and this can be seen within this theme and its subthemes which uncover important aspects of how theory is being put into effect in client work by the therapists who were interviewed.

It was evident that the therapists had developed their own particular style of working, which was influenced by their knowledge of other approaches and their understanding of what was useful. This idea of individuality crossed over to their perception of the clients, who they saw as unique.

Overall, ACT presents itself as flexible, in being open to adaptation and personalisation by the therapists and in being easily integrated with other models. This is consistent with the following core competencies of the ACT therapeutic stance, put forward by Luoma, Hayes and Walser (2007, p.219) in their manual 'Learning ACT':

> 3. The therapist avoids the use of canned ACT interventions, instead fitting interventions to the particular needs of particular clients. The therapist is ready to change course to fit those needs at any moment.
>
> 4. The therapist tailors interventions and develops new metaphors, experiential exercises, and behavioural tasks to fit the client's experience and language practices, and the social, ethnic and cultural context.

ACT is seen by the therapists as adding to, rather than replacing their existing ways of working. There is supporting evidence that training in ACT has been shown to produce generally more effective clinicians, as measured by client outcomes in Strosahl, Hayes, Bergan, & Romano's (1998) non randomized, controlled effectiveness trial.

The therapists also mention the importance of the clients' narrative when working with grief and the incorporation of sympathetic listening, evidence to support this was found from the clients perspective within the sub-theme '*therapists as listener',* this being a particularly valuable aspect of therapy for one of the clients (Jim). Client narrative can be associated with the ACT concept of cognitive fusion. Fusion to self as content based upon the conceptualized past can lead to limited self-

knowledge (Luoma, Hayes & Walser, 2007). This had been a particular struggle for one client who had struggled to find a *new self.* This study noted the use of acceptance and self-compassion in developing a sense of *self as context* which is able to just observe these past events and experiences, rather than being defined by them. Such an approach opens up new possibilities, this can be seen in the client theme *Finding new purpose & place in society*.

ACT is an active therapy incorporating a range of experiential exercises. The therapists in this study find that doing interventions *with* clients, rather than *to* clients in agreement with Harris (2007) leads to success, in his teaching manual he advocates the type of flexible approach adapted by these therapists, suggesting changing words to suit your own style and modifying to suit the clients.

3.6.3. Why therapists chose to use ACT

The study did not set out to look at why therapists chose to use ACT, but it is a very interesting emergent theme. The therapists all speak positively about the *freedom from struggle,* and losing the *control agenda.* Control strategies are usually put into place to get rid of 'bad' thoughts and feelings, this experiential avoidance is seen as pointless in ACT terms. ACT avoids focusing on control strategies because it holds that experiential avoidance is associated with higher levels of psychopathology (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004). As part of this, the therapists also talk about the move away from trying to fix things and from symptom reduction. Research has found support for the idea that focussing on controlling negative experiences is counterproductive (see review by Wenzlaff & Wegner, 2000) in that it can in fact increase the frequency of unwanted thoughts and can be emotionally and physically draining (see review by Baumeister et al., 2006).

Parkes (1996) had criticised group grief work as being in danger of implying that the client is in some way sick because of the use of approaches derived from psychiatric settings, the contextual philosophical underpinnings of ACT move away from this idea by recognising that concepts such as sick/well are culturally developed and not inherent in a person, but are ways of speaking or thinking which are helpful or not in any given context (Luoma, Hayes & Walser, 2007, p. 218).

Training in ACT was found to reduce burnout in substance abuse therapists (Hayes, Bissett, Roget, Padilla, Kohlenberg, Fisher, et al., 2004), this study also found that therapists reported positive feelings associated with bereavement work when using the ACT model. This had been particularly significant for one (Sam) who had previously disliked working with bereavement. The study found that therapists feel that they have less struggle and report seeing this in their clients too, describing seeing *a sigh of relief* when clients realise they can let go of the control agenda. This is evident in the clients' transcripts under the themes *intense emotional pain, intrusive thoughts, the development of new ways of being* and *learning to embrace the truth*, when they talk about how they have accepted the individual nature of their grief, their own needs and learned new ways to cope through fully experiencing their thoughts and emotions.

The therapists are clear in getting their point across that ACT works for bereavement, as yet there is no empirical evidence to support this, but the transcripts reveal that the therapists regard the approach as very workable and successful. To get a sense of the measure of success all the therapists were asked if they felt their clients achieved increased psychological flexibility, which is seen as the primary aim of ACT. From their responses it appears they qualify and measure this as: living a more fulfilling life (Frank), responding to the situation differently (Sophie), a

willingness to have emotions and a new sense of control (Sam), better functioning (Robert), a new way of looking at things (Dawn), and using positive language and having a more realistic outlook (Katy). These responses are discussed in more detail under the superordinate themes *Facing Grief with ACT* and *Why Therapists choose to use ACT* and are echoed by the clients in the theme *Change brought about by therapy*. The therapists see ACT as enhancing their therapeutic skills, when comparing to ways they had worked in the past. It is interesting to note that the therapists describe the benefits of letting go of 'the control agenda' and focusing on 'symptom reduction' they saw as present in CBT and REBT. This highlights one of the strengths of ACT being its ability to promote behaviours which are workable for each individual client, and focus on the positive rather than the unnecessary and time consuming work of challenging irrational beliefs.

3.6.4. The purpose of theoretical knowledge.

From the analysis, a distinction can be noticed between two types of knowledge. In theme two 'Factors shaping application' we saw the sub-theme *knowing is not living* which was concerned with experiential knowledge gained through practice or direct experience. This theme focuses on conceptual knowledge and includes the therapists' views on the purpose of theoretical knowledge. The therapists all valued and pursued further understanding and recognised the importance of sharing on a professional level. They took a leading role in teaching the concepts to their clients through modelling; using ACT consistent language in their own talk, which reinforces psychological flexibility.

The current study found the therapists talk suggested a degree of expertise in ACT, which in many ways led the direction of the sessions, yet there is no

suggestion that the therapeutic relationship was not an equal one. Grief therapy has been described as a being 'with the person' rather than trying to do something to alleviate their distress (Parkes & Weiss 1983; Worden, 1982), to this end ACT's therapeutic stance of being with the client as an equal, vulnerable, compassionate, genuine, sharing therapist (Luoma, Hayes & Walser, 2007; p.218) would fit these criteria. Although one of the therapists reported incorporating advice giving into his work, this reflected the context of his work which necessitated an element of practical support too.

So although the therapists are experts in terms of their knowledge of the theoretical background of the processes applied in ACT, they do not feel the need to pass on the conceptual knowledge they have. The theory is used as a means of thinking systematically about the therapeutic process. This would be consistent with ACT thinking which states language is used only as a tool to get in contact with something that is experientially relevant and not as a means of intellectualizing ACT ideas (Hayes, Strosahl & Wilson, 1999).

3.7 Conclusion

In conclusion, the current study provides preliminary support for the successful application of the ACT model to bereavement therapy. The results indicate positive outcomes for both therapists and clients particularly when dealing with emotional and thought related issues. ACT has been found to involve less talking and more doing, the consequences of this are less struggle for therapeutic change. The current study found ACT to be a flexible model which values the individual nature of each client, puts suffering into a positive context and promotes values driven growth in both therapists and clients.

Chapter Four

Thesis Discussion
&
Conclusion.

4. Thesis Discussion

This chapter will present a discussion of the thesis as a whole. It will begin by summarising the conclusions of the conceptual review (chapter two) which examined the fit of the ACT model and theory to the experience of grief and grief work. It will then summarise the key findings of the research report (chapter three) which was designed to provide some evidence, of the application of ACT to bereavement work, from both a therapist and client perspective. Key findings will be discussed in terms of the aims of the thesis, existing theory and research literature. Implications for counselling psychology practice will follow. Finally, limitations of the present study and a number of suggestions for future research will be discussed.

The conceptual review (chapter two) began by taking a critical look at bereavement literature and highlighted that the prevailing models of grief have been criticised as lacking an empirical basis, as failing to recognise the individual nature of the grief experience both individually and culturally, and as tending to pathologize grief. It also noted that the effectiveness of grief interventions is being questioned due to a lack of, or the limited nature of empirical studies, lack of clear guidelines on interventions and studies which fail to support the central tenets of therapeutic models which have been largely based upon stage models. In light of such criticisms, new treatment models are being developed to address previous short comings; however there is still the need for clear psychological models and novel therapeutic approaches which have been empirically evaluated to enable evidence based practice. ACT is emerging as a strong theoretically and empirically tested model; its success across a range of psychological issues has been shown, but to date, to the best of my knowledge, there is no literature which has matched the ACT model with the therapeutic needs of the bereaved. This conceptual review concluded that there

appears to be a good degree of fit between the ACT therapeutic model and the needs and aims of bereavement therapy, not least because, avoidance, lack of contact with the present moment, fusion with stories about the self and the deceased, loss of valued direction and lack of committed actions are commonly reported in the bereaved. The paper proposed that, in accepting grief as a natural process, therapeutic practice which facilitates the experiencing of emotions rather than avoiding them, is appropriate. This is supported by research which has found detrimental effects associated with attempting to suppress emotions (Baumeister, Gailliot, DeWall, & Oaten, 2006; Wegner & Zanakos, 1994). Interventions such as *reflection, staying in the here and now* and *giving permission*, may be useful ways of achieving this. Defusion techniques are proposed as interventions to contact and promote a secure sense of self, no longer fused to thoughts and events from the past, thus allowing clients to move forward with their lives. Whilst person-centred grief work allows for individual expression of grief, it has been criticized for not offering techniques to move the client beyond expression of emotion (Gilliland & James, 1998). As therapists it is valuable to have sound interventions to call upon, therefore it is proposed that through the employment of mindfulness techniques (an important component of the ACT model), clients can develop resilience and post traumatic growth, such as was reported by Siegel (2007; 2010) and found by Farb et al., (2007) in their study of mindfulness through observation of functional MRI scans.

It has been said that bereavement therapies should promote a sense of competence and hope for the future (Prigerson et al., 2004). The ACT model seems to be particularly suited to this aim, with its focus on identifying personally important values and creating meaning and hope in life. As such, these values are

empowering and promote positive, committed action to change, thus re-engagement in life.

Chapter three explored the experiences of both therapists and clients when using an ACT approach to grief work, through an IPA study. It was considered an important aspect of the research to collect both interpretations of the therapeutic experience, in order to avoid the criticism of only providing a limited picture of the true nature of therapy (Gordon, 2000) and to provide qualitative data from the perspectives of expert opinion and client experience, to enhance the evidence base (APA, 2002). The therapist and client interviews were analysed individually and then themes developed as two groups, but findings were later brought together through the process of triangulation to provide confirmation of the validity of the findings.

The background literature in the introductory chapter (Chapter one) presented evidence of the poor health outcomes associated with bereavement. The rating of death of a spouse was the most highly rated stressful event (Holmes & Rahe, 1967). Research has shown that bereavement interventions are best targeted at those who fall outside of normal grieving processes (Maciejewski et al. 2007; Parkes, 1996). Although defining 'normal grieving' is a contentious issue, the enduring and strong emotional responses observed in those who are struggling with their grief, affords recognition of the grief responses which are important to address in any grief intervention. Analysing the transcripts of both the therapists' and the clients' in this study produced some similar themes, which describe the grief response. For the therapists the emergent theme 'Facing grief with ACT' and the client group theme 'The presence of undesirable thoughts & feelings', showed the intensity of the felt emotions. The therapists were found to be managing the emotional states of their

clients through the use of acceptance, mindfulness and present moment awareness. As proposed by the conceptual paper (chapter two), the use of ACT in this way, encouraging a willingness to fully explore through mindfulness and present moment awareness, allows for a tangible comprehension of what is actually happening, rather than what the mind tells us the experience says (Hayes et al., 1999). The clients offered some support for this approach in their themes 'learning to embrace the truth' and 'the emergence of new ways of being'.

Traditionally CBT focuses on the cognitive challenging of intrusive thoughts and although successful when properly done (Butler, Chapman, Forman & Beck, 2006), it can be very difficult when the same mind which is trying to be rational is being influenced by sadness and the reality of the loss. Therefore achieving a mental distancing from the thoughts themselves, not by contradicting them, but by acknowledging them as just thoughts, is said to free up the mind and give a feeling of control (Hayes, Strosahl & Wilson, 1999). One of the clients (Jim) described his intrusive thoughts as the most troubling aspect of his grieving experience, feeling it was something he was unable to control. Both clients, in the client sub- theme '*intrusive thoughts'* go on to talk about how therapy has allowed them to gain control over their thoughts, allowing the thought to be there without taking over or needing to act upon it. These findings would support previous research stating that attempting to conceal thoughts and feelings has been shown to increase their frequency and intensity (Wegner & Zanakos, 1994). Several other notable comparisons were made with CBT, with therapists describing the *freedom from struggle* and *losing the control agenda*. This would offer some preliminary support for the proposals of the conceptual paper which suggest, in line with ACT principles, that there is no need to challenge thoughts and beliefs. As a functional contextual

theory, ACT emphasizes workability as a truth criterion. Therefore, thoughts and behaviours are not seen as being correct or incorrect but are seen as being questioned according to their usefulness in moving towards a more valued and fulfilling life. To this end no attempt to change the content of private events is necessary.

The conceptual paper contained within this thesis proposed that values are an important aspect in moving the client towards re-engagement in life, and the use of memories and a realisation that not everything has changed could be achieved by identifying memories of shared values. The initial study confirmed the importance of maintaining a continuing bond with the deceased and a continuation of traditional values for the clients in this study.

This research, not unsurprisingly, found anger and guilt present in the therapy sessions. In contradiction of the stage models of grief, there was no suggestion that they occurred at a particular stage in the grieving process. Flaxman, Blackledge & Bond (2011, p.29) talk of how such feelings of guilt can lead a person to define themselves as "bad". The conceptual review presented earlier, suggested how the key ACT concept of *self-as-context* could be applied, and it can be seen at play in the analysis when the clients are found to be defining *self* as commensurate to the content of their current thoughts, feelings and memories. For example, one of the therapists (Sam) used an example to illustrate this point when she quoted one of her clients as saying *"I don't feel guilty anymore; I don't feel bad about myself".* The interviews showed how, like with other troublesome thoughts, the clients in this study have been helped to overcome this by the introduction of defusion techniques.

The use of metaphor is a key element of ACT and this can be seen in the reflections of the therapists. Metaphors can be used in therapy derived from the client's spontaneous production of, or the therapist's choice of words. A metaphor

has been described as something relatively more concrete or conceivable which stands for something more elusive (Lakoff & Johnson, 1980). Salka (1997) proposes that the beginnings of successful [grief] therapy take place between the therapist and client on the conscious level, the advantage of using metaphor is its ability to access the unconscious mind "enabling those therapeutic messages, like seeds, to permeate the soil of the mind and become more firmly rooted…Real change is experienced when the unconscious mind is tapped into" (p.23). The therapists in the IPA study contained within this thesis select the metaphors they use according to their own preferences and as a way of making therapy relevant to each client. The study identified cultural relevance of metaphor to be important in influencing choice. Luoma, Hayes & Walser (2007; p250) describe inappropriate use of metaphor as one of the possible pitfalls or mistakes which could affect the therapeutic alliance. They state that "ideally ACT techniques are contextualised to the client's specific verbal behaviour in session, and metaphors and exercises are modified and tailored to fit them".

4.1. Implications for Theory.

Taken together the conceptual review and the research study provided within this thesis have a number of possible implications for the development of theory in the field of thanatology.

The findings from this research add to the growing number of studies showing favourable outcomes and promising conceptualisations of the ACT therapeutic model. They also contribute the beginnings of a novel approach to bereavement work which has a sound theoretical basis.

4.2. Implications for Counselling Psychology Practice

Counselling Psychology is underpinned by a humanistic ethos which values the primacy of the individual's experience. This research has seen how the ACT model encourages the development of therapeutic interventions tailored towards the experience of each individual client. Counselling Psychologists also place emphasis on the therapeutic relationship and the findings of this research would uphold the significance of such a value. Although it was not the intention to examine such relationships, the importance this was afforded by the clients, in terms of the amount of rhetoric in this area, could not be ignored and was accordingly recognised in their emerging themes.

Key elements of the Practitioner Doctorate in Counselling Psychology are the philosophical origins of the profession and self-care. Deurzen-Smith (1990) proposed that the philosophical underpinnings of counselling psychology are to be found between a psychology dedicated to scientific principles and the philosophical reigns of what it means to be human, and as such focuses on helping people to live more fulfilled lives. This philosophy fits well with the ACT goal of living a more fulfilling life (Harris, 2009; Plumb, Stewart, Dahl, & Lundgren, 2009). With self-care seen as critical within the profession, the benefits in reducing therapist burnout as found amongst substance abuse counsellors who adopt ACT into their practice (Hayes et al. 2004) are relevant, and are also supported by the findings of this study.

This thesis adds to the debate surrounding ACT's originality and its direct comparison to CBT and other therapies. Although it is beyond the scope of this thesis to discuss this in depth, it does offer some first-hand descriptions of the therapists' own perspective on the similarities and differences between ACT and other therapeutic models. This is an important debate to be involved in as Counselling Psychologists. The support for CBT to become the treatment of choice has been steadily growing and has

gained financial support through the nationwide initiative 'Improving Access to Psychological Therapies' (IAPT: Clark, Layard, Smithies, Richards, Suckling et al., 2009; Layard, Bell, Clark, Knapp, Meacher et al., 2006). Whilst IAPT may be built on strong evidence as an empirically supported therapy, other emerging therapies such as ACT may be being over shadowed. This thesis has also highlighted the need for more appropriate ways of working with clients to filter through to current practice. Stewart and Chambless (2010) point out that research which sets out to advocate empirically supported treatments is having little impact on the actual practice of front-line practitioners. Identifying and endorsing psychotherapies as empirically supported is not, in itself achieving successful dissemination to therapists (Cook, Weingardt, Jaszka, & Wiesner, 2008).

It is suggested that research findings should be presented in a form practicing therapists can easily use, rather than being directed at academic circles alone. It is hoped that by presenting a theoretical paper and an IPA study, this thesis will provide a useful guide for therapists interested in this area. The qualitative data may also contribute to the evidence base with its preliminary findings from the important aspects of expert opinion and client experience (APA, 2002). It is important for Counselling Psychologist to use their scientist-practitioner role to investigate the different approaches independently and come to their own conclusion given the available evidence base. Clinical intuition and experience may also be needed to decide which approach would be most suitable for a given client.

The current research could also be seen to contribute to the need for better psychological knowledge and understanding of therapeutic approaches in the implementation of grief services. Therapists often find this an uncomfortable area in which to work, but this research has shown in five of the therapists interviewed here that ACT has the potential to relieve some of that angst.

All the therapists interviewed for this study reported that in their experience ACT works for the treatment of grief, five of the six therapist reported fewer struggles, and whilst strongly linked to theory they all recognised ACT as a flexible model which does not need to be followed in a structured manner, freeing up both the therapist and the client to produce unique therapy tailored to the individual.

Whether ACT works better than existing models, such as CBT, for bereavement work, is an empirical question yet to be answered. However, this thesis marks the first step toward evaluation and dissemination of the ACT therapeutic model for bereavement work. Hopefully, greater understanding of the available research will result in treatment of the bereaved that is less judgmental and more facilitative of their healing and growth.

4.3. Limitations of the study

As an initial exploration into the fit and application of the ACT model to grief work, this study is limited by its uniqueness. Unfortunately due to the concept of ACT work for bereavement being in its infancy, the sample was small. The two clients who were interviewed had both been bereaved by loss of their spouse. Therefore the findings could be said to be relevant in this specific area only. This study did not attract any therapist or clients who had had negative experiences of applying ACT in the treatment of grief, whilst there was no deliberate attempt to exclude such participants it is recognised that if there are any difficulties with the approach, this study has not been able to explore them. As such it could be seen to be biased; this may be a consequence of the recruitment process which only used the ACT special interest group. The therapists who did volunteer were able to provide detailed accounts of their experiences of using the approach, but it could be argued

that they had strong allegiances to the model. However, the study did recruit on a global level reflecting the growing popularity of ACT.

This global recruitment did mean that all the interviews could not be conducted using the same modality and it must be acknowledged that this may have affected the level of disclosure by participants in this study. Telephone interviews provide higher levels of anonymity (Kazmer & Xie, 2008), and may allow for more disclosure. However video-mediated communication is said to closely duplicate the experience of face-to-face meetings (Campbell, 1998), but relies upon the users feeling comfortable with the medium. Whilst face to face interview is seen as the "golden standard" (McCoyd & Kerson, 2006) using the full screen on Skype can mimic face to face interviewing by reducing long silences, and create a more realistic experience which can make use of visual cues (King & Horrocks, 2010).

Although there are concerns about the generalisation of qualitative research findings, the aim of this study was deeper understanding on an individual level.

4.3.1. Methodological critique

Analysing and interpreting the interview transcripts was influenced by the researcher's understanding of the nature of ACT and bereavement therapy, and by the face-to-face experience of interviewing this client group and fellow therapists. Whilst every effort was made not to be influenced by personal perspectives, as a reflective practitioner this element is recognised as being present. IPA recognises the double hermeneutic of the researchers own journey into trying to make sense of the participant trying to make sense of their experience (Smith, Flowers & Larkin, 1997).

Notwithstanding this, IPA was chosen over other types of qualitative analysis that were considered possible alternatives (Discourse analysis, Narrative analysis) due to

its concern with giving a more detailed and nuanced account of the personal experiences of a smaller sample (Smith *et al.* 2009).

Discourse Analysis (DA) was considered inappropriate, as whilst IPA is concerned with cognitions and sense-making, DA is sceptical regarding the accessibility of cognitions, with its focus on language in terms of its function in constructing social reality. IPA recognises that cognitions are not transparently available from verbal reports, but engages with the analytic process in the hope of being able to say something about the sense- and meaning-making involved in such thinking (Smith, Flowers & Osborn, 1997; Smith *et al*. 2009).

Narrative Analysis was also considered as it is concerned with meaning-making, but was discounted as it focuses more upon the structure of people's stories. Narrative is only one way of meaning-making (others include discourse and metaphor), and so it was felt that IPA, which includes recognition of narrative in the sense-making of participants experiences but is not constrained by this focus (Smith *et al.* 2009), was more in keeping with the aims of the study.

4.4. Suggestions for future research

This novel piece of research in the area of bereavement opens up the possibility for further detailed exploration. The numbers involved in this study naturally restrict its ability to provide generalised findings; it would therefore be beneficial to conduct research on a larger scale. This study also recognises that broader recruitment of participants may allow for any negative aspects or difficulties, if any, to be explored. This could be beneficial in identifying any clients or client groups where applying the ACT model may not be helpful before we can assume it is an appropriate treatment for all. If numbers eventually allow, quantitative outcome studies would be valuable. Meanwhile the use of case studies could provide a

systematic way of looking at the process and outcome of change by allowing for a specification of techniques and isolation of change mechanisms.

There is also the opportunity to explore less specific experiences. As pointed out earlier, both participants in this study had been bereaved by loss of their spouse, other types of bereavement, i.e. loss of child, loss of parent, death by suicide, sudden death all warrant further exploration. The goal of ACT is seen to be the development of psychological flexibility; this is seen as transferable to other aspects or life experiences. Follow-up or longitudinal studies could be valuable in examining the longevity of such therapeutic change.

Whilst research into ACT is growing quickly, there is a void in the area of bereavement. Exploration of the individual elements of the ACT model in relation to specific grief responses could provide valuable information to shape the practice of therapists. For instance, the adaptive significance of grief, the mechanism that initiates the grief response, the mechanism that leads to the resolution of grief, and sources of individual variation.

The findings in this study highlight the personal struggles experienced by therapists when working with bereavement. In line with the preliminary studies of Hayes et al (2004) and Dahl, Wilson, & Nilsson (2004) into professional burnout and stress respectively, this study found benefits to therapist wellbeing, associated with employing an ACT philosophical position. An extension of these studies on an individual and organisational level is suggested.

4.5. Conclusion

This thesis provides preliminary support for the use of ACT in the treatment of grief, demonstrating some success in a small number of therapists and clients,

based upon the theoretical fit of the model to typical grief responses and the findings of the initial study. The therapists' theme '*Facing grief with ACT'* and the client theme '*The presence of undesirable thoughts & feelings'* provides qualitative data which to date are not available in current bereavement literature. Whilst the ACT literature provides evidence of the effectiveness of applying the six core elements across a wide range of psychological problems (Hayes et al., 2006), it has not been examined in relation to grief. Therefore this study adds to existing literature in both areas. The study supports current ACT literature concerning emotional control (Hayes, Strosahl & Wilson, 1999; Wegner & Zanakos, 1994), and bereavement literature which argues that suppression of grief can be harmful (Bonanno & Kaltman, 1999; Stroebe & Schut, 1999). The conceptual review hypothesised that values work could be an important way of encouraging re-engagement in life; this was confirmed by the finding of the initial study in the therapist sub-theme '*doing what works'*, and adds to current thinking that successful adjustment following bereavement is marked by an acceptance of the reality of the loss and a re-engagement in life (Balk, 2004; Corr, Nabe & Corr, 2003).

Chapter Five

Critical Appraisal of Research Process

Critical Appraisal of Research Process

As a counselling psychologist I see myself as an integrative practitioner whose philosophical roots are found within a humanistic and existential-phenomenological psychology in which the search for understanding and meaning is central, this occurs through scientific research and an engagement with the subjective experience, values and beliefs of my clients. As such, I am always looking for ways to add to and improve my own practice and develop new ways of working.

The idea for my research developed from a marriage of two areas of particular interest to me. I began working as a bereavement counsellor four years ago and as I progressed through my training at both bachelor and doctoral levels I became more and more interested in this area of work, many of my presentations and essays focused on grief and loss. Whilst working as a volunteer and having undertaken the 'Cruse' training programme, I felt that although their person-centred approach seemed popular, for me it lacked something. Through conducting this research I came to realise that it was the therapeutic tools to move clients on and offer them hope for the future which I was seeking.

As an undergraduate student I listened to a lecture which very briefly introduced the idea of ACT whilst looking at the topic of clinical psychology. Immediately it struck a chord with me, it seemed to make sense and offer a model which I could relate to in terms of some of my own life experiences. Once I began the doctorate level course I began to find out more about this approach and the lecturer who first introduced the idea to me, became one of my supervisors for this research. Smith (2008) talks of 'learning hooks' when he describes how our attention and interest is captured and causes us to engage further. This has certainly been the

case for me with these two topics and I soon began to realise the potential for exploring the value of their use together.

As a 'scientist-practitioner', synonymous with the profession of Counselling Psychology, I found myself caught in several dilemmas, firstly between respect for the personal, subjective experience of the client over and above notions of diagnosis, yet working in mental health settings where notions of 'sickness' and the associated labels that go with the concept of mental illness are common, and secondly, the pursuit of innovative, phenomenological methods for understanding human experience and the drive for evidence-based practice. I have come to reconcile this debate through viewing the scientist-practitioner model as a continuum. I view myself as closer to the practitioner end of the scale, yet experience this as a fluid process of development. My reading has reflected this. The practitioner doctorate does not teach a module specifically on ACT, it was therefore up to me to learn for myself. I began by reading one of the more theory based textbooks (ACT: An experiential approach to behavior change by Hayes, Strosahl & Wilson, 1999); I found this very hard going, particularly getting my head around Relational Frame Theory, on which ACT is based. I gave up half way through and changed to more practical books, such as *ACT made simple* (Russ Harris, 2009). Here my understanding began and once I could see aspects of the model at work in my practice, it became clearer to me. I also sought out other ways to learn and utilized any available on-line training materials. I guess much like the ACT model and ACT training postulate, learning is best achieved experientially. I was fortunate that my placement supervisor supported my development in this area. As I began to read more journal articles and empirical research I realised how well ACT champions the scientist-practitioner model, with so much of its research being based within specific

clinical populations. Once my confidence at this level was increased, I then felt the need to gain greater understanding of the underlying theory and returned to the original book. This time I was able to understand things more clearly and eventually found this to be the most useful reference book when writing up my research. I think this, for me, highlights the importance of this dual aspect to our profession, without the initial theory to interest me I would not have sought out the ways in which to practice the approach, this then led me back to the theory which deepened my understanding and has allowed me to empirically justify my practice and expand my knowledge into this new area via my research. Thus, my scientific search is therefore in service of my practice.

I was initially very excited when I could find no research which put ACT with bereavement work. It seemed an obvious connection to me. I felt sure that practitioners who were using ACT in other areas must be using it with their bereaved clients. I joined an ACT special interest group and sent out an email to the group to see the response. It appeared that some practitioners were indeed using ACT with clients who had been bereaved. This was the information I needed to get the project underway and my research proposal was prepared.

The preparation of a conceptual review paper helped me to test out my ideas, to develop them into something more concrete, and allow for a more detailed evaluation of ACT principles and grief issues. This became the foundation for the research. I intend to submit this paper to 'Death Studies' for publication to disseminate this new approach for consideration by those working and researching within this field.

On reflections my expectations were fuelled by my enthusiasm rather than being realistic. Recruitment was difficult; I was relying on the sheer good will of

busy practitioners to give up their time. My method of recruitment proved more difficult than I had first imagined too. I had no replies to the first post on the ACT special interest group webpage, after a second I had three. I was encouraged, however, when I received a reply from Steven Hayes (the originator of ACT), suggesting I tried contacting members individually. At this stage I felt very honoured, as I took this to mean that he viewed my research as appropriate and interesting enough for him to find the time to mail me personally. Accordingly I then tried a more direct approach and contacted ACT therapists personally via email. This was more productive, and resulted in recruitment on a global level, something I feel proud of. Yet it also posed additional problems. With the ACT community relatively new and spread out across the globe, I needed to think outside the box. My supervisor suggested I could use Skype to interview participants in Australia and USA (all the while staying in contact with the ethics committee who approved these approaches). After the first interview using this method proved a success, I decided to use it with those therapists who had the facility here in the UK to save on my travelling. I also seriously underestimated the time it would take to set up these interviews, and the problems with time zones. To suit the participant in USA I conducted the Skype interview at 10pm on a Sunday evening, the Australian interviews were conducted early in the mornings. I conducted the first interview on University premises to ensure that technical support was available should I need it, but I realised it would be easier to conduct the others from home once I had recording equipment set up. A trip to Plymouth took numerous emails and four months to find a mutually convenient date to meet up and involved an overnight stay for myself. However I was pleased that I persevered with this arrangement as I felt it was a particularly valuable interview which not only greatly impacted on my

research but also gave me lots to think about as a therapist. In fact I have really enjoyed meeting all the therapists and analysing the interviews, and have gained a great deal professionally from talking to other bereavement therapists about their experiences. A trip to Cambridge also involved a long drive and early start, but again was well worth the effort. One interview was excluded as although the therapist was an experienced ACT practitioner, despite my best efforts to steer her onto the topic of bereavement, she continued to focus on addiction work which was her specialism. I could see no value in including this in the study. Overall I am very pleased with the therapists I recruited; some of whom are prominent and well respected members of the ACT community. I am also pleased that, despite the challenges, I managed to interview everyone who came forward to take part in the study. As a researcher I have learned the value of being flexible in order to maximise recruitment potential.

Whilst I had to conduct the interviews using different modalities for financial and practical reasons, it was not easy to ascertain whether this affected the level of disclosure from the participants. I was aware to try and establish rapport and trust whichever mode I was using, and to check that the interviewee was comfortable. Each method had its own drawbacks, one of the face to face interviews was interrupted by the post man, another was time limited due to the therapists other commitments. One Skype interview lost visual contact and had to be continued using voice only, in another the participant's cat kept walking in front of the screen. To produce higher levels of standardization and uniformity ideally any further research would aim to utilize the same mode of data collection to obtain more rigorous results.

On reflection, and to the great surprise of me, my supervisors, and ACT therapists whom we know, recruiting the therapists was relatively easy compared to

recruiting clients. When I initially proposed the research idea to my course leader, she suggested that it would be sufficient to just look at therapists' experiences. I felt, however that it was vital to get the bigger picture. What is the point of research if it does not put the client first? As a counselling psychologist I believe client experiences and outcomes are the goals of all therapeutic intervention, so I persevered with my hopes and aims for the study. I found literature which agreed that approaches to research which look at understanding theory but fail to address the client's interpretation of events, provide only a limited picture (Gordon, 2000) and serve to increase the gap between research and the conduct of therapy by selecting to study phenomena which relatively easy rather than that which is important (Greenberg, 1986).

At this point I did begin to panic, I was relying on the therapists I had spoken to recruit suitable clients for me to interview. Initially no one came forward, as either the clients were not interested or the therapists felt they were not ready. I was not willing yet to give up on this important aspect of my research. In supervision we discussed other options, such as workshops for the bereaved, followed by questionnaires or interviews. I was not keen as it felt a move away from my original idea. I continued with my persistent emails and waited patiently. Eventually three clients were identified. After email correspondence with one client in the USA, who initially appeared keen, he failed to reply to me to arrange the interview. This was again disappointing. Two clients eventually came forward from Australia, so I set about arranging mutually convenient times for these interviews, one via Skype, the other on the telephone. This was potentially problematic too as I was relying on my Dictaphone recording the conversation from my telephone which was on 'loud speaker'. Thankfully this was successful. I was not overly concerned about

conducting the interviews, as an experienced grief counsellor I felt confident to handle the interview respectfully and sensitively, although I was in a researcher role I was constantly aware of the clients' needs and was prepared to use therapeutic interventions or to stop if necessary in accordance with ethical guidelines.

Although disappointed to only have two clients in the study, I feel this was worth the effort it took and I was very grateful that they took the time to share their personal experiences with me. At this stage I felt relief that despite not recruiting on the scale I first envisaged, I had been able to hold fast to my original goals for the research. I now knew the rest of the study was reliant on my hard work alone.

The process of transcribing and analysis began, and yet again I had drastically underestimated the amount of time this would take me. I had conducted IPA research before, but on a much smaller level with interviews lasting only about 20-30 minutes. I had not anticipated the sheer volume of data that would emerge from these interviews which were up to one hour long. My supervisors wanted me to conduct my analysis in computerised format; I can only describe this as a nightmare. Although it made sharing the analysis for the purpose of validation easier, I found that I felt slightly detached from the data itself and reverted to initially scribbling my own notes on paper copies. Obviously this took me much longer as I then had to transfer this information to computerised data records. If conducting IPA research again I would avoid this duplication of work by adopting a paper only approach to the analysis. This would also avoid another problem I encountered. To enable the reader to find quotes within the main transcripts I needed to provide line numbers, however this was not possible with the formatting I used in the production of the IPA analysis tables. This resulted in the need to include both within the confidential attachment and as such produced a lot of necessary but avoidable extra material.

Whilst acknowledging that the purpose of IPA is to immerse oneself in the data, after six weeks of analysis and endless options for themes, I felt overwhelmed by the sheer volume of interesting and relevant information contained within the transcripts. Eventually the themes emerged which I felt happy with and which fitted with the sense of the experience I had felt from the interviewees. I was aware that the written word cannot always convey the power of people's feelings and the depth of the impact of their experiences; to this end I felt that it was my responsibility to try and recognise this within the analysis. Whilst this process is dependent upon, and limited by my own ability to express those experiences, it was important to me that the emergent themes where not only transparent but also 'felt' right in the context of the interviews I had been part of. The transcripts were more than just words to me; I could hear their voices, remember their tone, hear or see their expression, so I had to reflect my understanding of this within the research.

Whilst analysing the transcripts I became aware at times that my own views were somewhat reflected in my comments, although trying to remain neutral so as not to influence the data, I noticed how I seemed to agree with the participants at times, sometimes to encourage them or sometimes whilst offering therapeutic reflection to assure them they were being heard. I do not feel disappointed by this, as I think it is important in an IPA study to connect with the participant in order to gain a deeper understanding. I also recognise that as a reflective practitioner it is important to be aware of the 'lenses' through which I perceive and frame reality and the inevitability of their presence. I was also aware of the times when I was surprised by responses or emerging topics, and recognised these as important for their clear relevance to the participants as opposed to my own thinking. The positive language used throughout this thesis may in part reflect my personal enthusiasm for the

approach, which was also fuelled by the sense of enthusiasm I felt from the therapists I interviewed. It may also reflect my desire to find a more positive way of working with bereaved clients having witnessed their distress in sessions. This in some ways is an example of the enthusiasm for the approach which has been a main criticism of current ACT literature and which I discuss in Chapter One, 'How successful is ACT?' I do however hope that I have not gone beyond my data and that the reader can draw their own conclusions or indeed try implementing aspects of the approach into their practice and then form their own opinion on the value of the model.

Whilst being involved in the whole research process I have had to manage several personal and research related challenges. Using ACT thinking in my own life has helped me to move beyond these problems, in particular my own fusion with evaluations and judgements about my ability as a researcher. When I noticed these as present, I realised they held no function other than to hold me back. Therefore I worked at holding them lightly and persisting forward towards my end goal. Each time I was able to do this, I progressed past another stage until my project was completed. I also tried whenever possible to find the time for my own mindful practice, I found this cleared my head when the workload was becoming overwhelming. I have also found using present moment awareness useful when I have found my attention caught up in the worries associated with a conceptualized past or future. I see it as important to be 'practicing what I preach' if I am to model psychological flexibility to my clients. The notion of 'being' is a core concept within ACT and mindfulness based practices and an interesting point on which to reflect. We are 'human beings' not 'human doings' and this is often an alien concept for us to adjust to in our busy, ever *doing* lives. But 'being' is not a state of *non-*

doing, it is living fully in the experienced moment. This research highlighted the different levels of knowing in the therapists theme *knowing something is not living it*. In this theme reference is made to a state of being with the experience rather than understanding on a conceptual level. So it appears that by *being* we can experience a deeper level of knowing. This in turn, I believe, is connected to our own state of contentment and satisfaction with our lives, the endless search for happiness is an impossible task, due to its transient nature, yet *being* allows for a full experience which might have otherwise been missed.

The sense of achievement I feel having pursued my vision for this research is hard to put into words. As a mature student I always had some self-doubt in my academic ability, particularly when it came to computers! But I have proved to both myself and others, that it is never too late to chase your dreams if you find your true vocation. I hope this will be the start of a promising career for me as a counselling psychologist, and this research, I hope will be as valuable to others as it has been to my own practice in this area.

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